

070169 OCT 29 1987

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8730604

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) LOTTIE ALICE ANDERSON			2a DATE OF DEATH MONTH DAY YEAR 10 21 1987			2b HOUR 9:30 P.M.		
3 SEX F	4 RACE CAUC.	5 DATE OF BIRTH MONTH DAY YEAR 2 15 1897		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7a BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN) MARYLAND		
7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD				
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clearview Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET ADDRESS / ZIP CODE 1209 Salem Avenue		14 FATHER'S NAME FIRST MIDDLE LAST William Long		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian E. Long		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b SOCIAL SECURITY NO 219-54-0337		17 INFORMANT ADDRESS 1209 Salem Ave.		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) Wound Infection DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Brain Syndrome			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 7 days 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Alimentia, inanition, malnutrition, exhaustion of organism								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2, OR PART 2)				
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION (CITY OR TOWN COUNTY STATE)				
22a I certify that (1) (this hospital) attended the deceased from 10/17/87 to 10/21/87 that (1) I last saw the deceased alive on 10/20/87 19 and that in my (own) opinion death occurred on the date and hour and from the causes stated above; (2) I was did not view the body after death								
22b SIGNATURE Edwards Thordy		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/21/87		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Oct. 24, 1987		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION (CITY OR TOWN COUNTY STATE) Hagerstown, Wash., Maryland		
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a DATE REC'D. BY REGISTRAR OCT 28 1987		25b REGISTRAR'S SIGNATURE John P. Smith		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070100 OCT 20 67



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U.S. AIR FORCE

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE FURNISHED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b HOUR
		Myrtle C. BALLOW					DATE ESTI MATED		10	11	1987	3:45 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	9 NEVER MARRIED	10 DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR
Female	White	November 21 1894	92 YRS.	New York	U. S. A.	WIDOWED	DIVORCED	10	11	1987		2:45 PM
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY						
Middletown		Rfd. 1 Box 134		Clerical		Government						
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS		13e STREET ADDRESS				
Maryland		Washington		Middletown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rfd. 1 Box 134		21769		
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST				FIRST MIDDLE LAST								
Chockley				Julia Hunter								
16a WAS DECEASED EVER IN U.S. ARMED FORCES?				16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS				
No				578-52-7783		Edward B. Ballow		Rt. 1 Box 134 Middletown Md. 21769				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b) <u>#428</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
				HOUR A.M. MONTH DAY YEAR								
				P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION				
								STREET CITY OR TOWN COUNTY STATE				
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <u>Edward W. Dittus</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER DATE SIGNED <u>10/11/87</u>				
EXAMINER'S NAME (TYPE OR PRINT) <u>Edward W. Dittus</u>				ADDRESS <u>217 W Washington St</u>				CITY OR TOWN <u>Smithsburg</u> COUNTY <u>Wash. Co.</u> STATE <u>Md.</u>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		23e REGISTRATION				
Cremation		1012-87		Smithsburg Crematory		Smithsburg, Wash. Co., Md.						
24 FUNERAL DIRECTOR NAME <u>John H. Bast, Jr.</u>						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
Bast Funeral Home, Boonsboro, Md. 21713						OCT 15 1987		<u>Julia Davidson-Randall</u>				

068971 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Armatha Virginia Barnhart</i>			2a DATE OF DEATH MONTH DAY YEAR <i>10 15 87</i>		2b HOUR <i>1⁴⁵ A.M.</i>
3 SEX <i>Female</i>	4 RACE <i>Caucasian</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>10 10 21</i>		6 AGE (IN YEARS (LAST BIRTHDAY)) <i>66</i> YRS.	IF UNDER 1 YEAR MONTH DAY IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD	
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cotton Village Nursing Center</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>meat wrapper</i>		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i>		13b COUNTY <i>Washington</i>	13c CITY OR TOWN <i>Hagerstown</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <i>25 Winter St.</i> 21740
14 FATHER'S NAME FIRST MIDDLE LAST <i>Harlan W. Smith</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Barbara E. Lewis</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO. <i>215-14-2171</i>	17 INFORMANT ADDRESS <i>9 Chestnut Ave. 432-2093 21713</i> <i>Robert G. Barnhart, Jr., Boonsboro, Md.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinoma of Colon</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Abdul Wateed</i>		DEGREE <i>M.D.</i>		22c DATE SIGNED <i>10/17/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>ABDUL WATEED M.D.</i>		22e ADDRESS <i>1610 Oak Hill Ave. Hagerstown, Md</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b DATE <i>Oct. 17, 1987</i>	23c NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>
24 FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i> 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a DATE REC'D. BY REGISTRAR <i>OCT 19 1987</i>		25b REGISTRAR'S SIGNATURE <i>James Davidson-Randall</i>

BP _____
DHMH-16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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070164 OCT 29 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gorman Bryan BETTS			2a. DATE OF DEATH MONTH DAY YEAR October 24, 1987		2b. HOUR 2 P M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR January 23, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 300 West Howard Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sheet metal worker	12b. KIND OF BUSINESS OR INDUSTRY aircraft	
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 300 West Howard Street 21740
14. FATHER'S NAME FIRST MIDDLE LAST Josiah Betts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Daryer Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-09-4971		17. INFORMANT ADDRESS Mrs. Mary R. Betts, Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Organic Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b). <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>9/15/87</u> to <u>10/24/87</u> that (I) (we) last saw the deceased alive on <u>10/24/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Andrew L. H...</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>10/26/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>1825 Howell Rd</u>		22e. ADDRESS <u>Hagerstown, Md 21740</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Oct. 27, 1987	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		25. DATE REC'D BY REGISTRAR 25. REGISTRAR'S SIGNATURE OCT 28 1987			
415 East Wilson Blvd., Hagerstown, Maryland 21740					

BP

DHMH 16 60M 7/84
(VRA 15, 4)

070106 OCT 59 85

Organic Brown pigment
Adrenochrome

10/18/59

10/18/59

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068237 OCT

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 10-2 87 2:40 PM											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACK LEROY BOWARD										7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-2 87 3:00 PM											
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1931		6 AGE (IN YEARS) (LAST BIRTHDAY) 56 YRS		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN											
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 Separated MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD									
10 CITY OR TOWN OF DEATH Williamsport				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 3, Box 299				12a USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE painter				12b KIND OF BUSINESS OR INDUSTRY									
13a STATE Maryland										13b COUNTY Washington		13c CITY OR TOWN Williamsport		13d INSIDE (CITY LIMITS)? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Route 3, Box 299		21795			
14 FATHER'S NAME FIRST MIDDLE LAST Fred Boward										15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Foltz											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b SOCIAL SECURITY NO. Korean 212-24-5689				17 INFORMANT ADDRESS Mr. Rodney Boward, Williamsport, MD.													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA, RT. NECK DUE TO, OR AS A CONSEQUENCE OF #195 - ONE YEAR (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE													
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE George Milic										TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT) GEORGE MILIC, M.D.										DATE SIGNED 10-2-87											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial										23b DATE Oct. 5, 1987		23c NAME OF CEMETERY OR CREMATORY Rock Gap Cemetery				23d LOCATION CITY OR TOWN COUNTY STATE Flintstone Allegany, MD.					
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME										25a DATE REC'D. BY REGISTRAR OCT 8 1987				25b REGISTRAR'S SIGNATURE							
415 East Wilson Blvd., Hagerstown, MD. 21740																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM VA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP
DHMH-17
(VR A15 ME (1))

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069087 OCT 20 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been assigned by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTIE PEARL BOWMAN			2a. DATE OF DEATH MONTH DAY YEAR October 14, 1987		2b. HOUR 5:45 A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 25, 1898		
6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.				
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Coffman Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		
12b. KIND OF BUSINESS OR INDUSTRY HOME		13a. STREET ADDRESS / ZIP CODE 710 W. WASHINGTON STREET 21740				
13b. STATE MARYLAND		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES CLINTON BOWMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE MAE SCADEEN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-10-2870		17. INFORMANT ADDRESS FRANCES M. RANDELL SAME AS 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF AND (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MANY YEARS MANY YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (XXXXX) attended the deceased from JULY 28 , 19 83 , to OCTOBER 14 , 19 87 , that (I) (XX) last saw the deceased alive on OCTOBER 12 , 19 87 , and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (XXXX) did not view the body after death.						
22b. SIGNATURE <i>Edward W. Ditto, III</i>		DEGREE M.D.		22c. DATE SIGNED OCT. 14, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.		22e. ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-16-87		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. PK.		
23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH. MD.		24. FUNERAL DIRECTOR NAME ADDRESS GERALD N. MINNICH 305 N. POTOMAC STREET HAGERSTOWN, MARYLAND				
25a. DATE REC'D. BY REGISTRAR OCT 19 1987		25b. REGISTRAR'S SIGNATURE <i>Julia D. ...</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Anna Ellen Bowser			2a DATE OF DEATH MONTH DAY YEAR Oct 29, 87		2b HOUR 125 A.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 1 10 1892		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
7a BIRTHPLACE (COUNTRY) USA MD	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Williamsport	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Williamsport Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home
13a STATE Maryland	13b COUNTY Washington	13c CITY OR TOWN Williamsport	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 154 N. Artizan St.	
14 FATHER'S NAME FIRST MIDDLE LAST Eugene McCardell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EFFIE King			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 220-48-9830		17 INFORMANT ADDRESS Edith Harsh Williamsport 223-7443	
18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause a) stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from Oct. 16, 1986 to Oct. 29, 1987 , that (2) we last saw the deceased alive on Oct. 22, 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (3) we did (did not) view the body after death.					
22b SIGNATURE J E Howe MD		DEGREE		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) TED E. HOWE		22e ADDRESS OWEY, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (TYPE IF Y)		23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE
Burial		10-31-87	Riverview Cemetery		Williamsport Wash. MD
24 FUNERAL DIRECTOR (NAME)		ADDRESS		25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE	
Major M. Osborne		P.O. Box 348 Williamsport		NOV 2 1987 Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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100-100000-100000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Myrtle Estell BUONOCORE			2a. DATE OF DEATH MONTH DAY YEAR October 30, 1987		2b. HOUR 4:00 P.M.
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR October 15, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 650 North Prospect Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7 East Washington Street 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Will Gaskins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	16b. SOCIAL SECURITY NO 240-12-7599	17. INFORMANT ADDRESS Mr. James Evans, Hagerstown, Maryland			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) POSSIBLE CARDIAC arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ATHERO SCLEROTIC CARDIOVASCULAR DISEASE. DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE CARDIAC ARRHYTHMIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE					
19a. DATE OF OPERATION 9/29/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY HEART DISEASE		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from 9-27-87 to 9-27-87 that (I) (we) last saw the deceased alive on 9-27-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE Monaf		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mangae J. Shafi, M.D., P.A.		22e. ADDRESS 368 Mill St. Hagerstown, Md 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE November 3, 1987	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR NOV 04 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
415 East Wilson Blvd., Hagerstown, Maryland 21740					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

070040 101-541

RECEIVED
FEB 10 1964

COMMUNICATIONS SECTION

101-541

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TIME: [illegible]

BY: [illegible]

070919 NOV

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) William F. Campbell SR.			2a DATE OF DEATH MONTH DAY YEAR 10-26-87			2b HOUR 11:35 PM	
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR April 26 1931	6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	9b CITIZEN OF WHAT COUNTRY? U.S.A.	10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD			
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Md.			13b COUNTY Wash.	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 462 Sumans Avenue. 21740
14 FATHER'S NAME FIRST MIDDLE LAST Theodore NMN Campbell			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora B. Stribling				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-18-3297		17 INFORMANT ADDRESS Catherine Briscoe 114 Charles St.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute pulmonary edema. hours DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart disease DUE TO, OR AS A CONSEQUENCE OF (c): PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 1-29-85 to 10-26-87, that (I) (we) last saw the deceased alive on 8-30-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b SIGNATURE Charles C. Spencer M.D.				22c DATE SIGNED 10-28-87		22d ADDRESS 1198 Kenly Avenue Hagerstown, MD 21740	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/31/87		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.	
24 FUNERAL DIRECTOR NAME Dennis L. Davis-Smith Burg, Md. 21783				25a DATE RECD. BY REGISTRAR OCT 29 1987			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page and pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG NO

1. DECEASED NAME (TYPE OR PRINT) John L. Carbaugh				2a. DATE OF DEATH MONTH DAY YEAR Oct. 19-87		2b. HOUR M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR February 4, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) freight conductor	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry W. Carbaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Edith Stoner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-05-2379		17. INFORMANT ADDRESS Katherine I. Carbaugh, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Abdul Wateen MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
ABDUL WATEEN MD				1610 - OAK HILL AVE. HAGERSTOWN - MD.			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) burial		23b. DATE Oct. 22, 1987		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D BY REGISTRAR OCT 28 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

10142 21101

2105261X
2105261X
2105261X
2105261X

2105261X

067765 OCT -78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RICHARD M. CARSON			2a. DATE OF DEATH MONTH DAY YEAR 10 - 3 - 87		2b. HOUR MIN 2:10 AM
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 - 30 - 14		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTH DAYS 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON County Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. GOVT		12b. KIND OF BUSINESS OR INDUSTRY Agriculture
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Otho E. Carson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora Snyder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-44-7535		17. INFORMANT ADDRESS 112 Orchard Dr. Mrs. Mildred C. Carson, Boonsboro, Md. 21713	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last Carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of prostate					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. S. [Signature]		DEGREE MD		22c. DATE SIGNED 10/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WATHERED MD		22e. ADDRESS 1610 - Oak Hill Ave HAGERSTOWN, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-5-87	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Boonsboro, Wash. Co., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713		25a. DATE REC'D BY REGISTRAR OCT 06 1987			
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

081762 OCT-70T

10/10/70

112 Locust St. 21713

W. J. Jones, Wilmington, Delaware

10/10/70

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OCT 08 1970

John H. Jones, Jr., Wilmington, Del. 21713

112 Locust St. 21713

068826 OCT 16 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a DECEASED NAME (TYPE OR PRINT) Edna Butler Cave			2b DATE OF DEATH MONTH DAY YEAR 10 11 87			2c HOUR 2:30 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 1, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 89		7 UNDER 1 YEAR MONTH DAY HOURS MIN YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Marlowe, W. Va.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10 CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Boonsboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS & ZIP CODE Rfd. 1 Box 154 21713	
14 FATHER'S NAME First MIDDLE LAST Frisby Kelly				15 MOTHER'S MAIDEN NAME First MIDDLE LAST Elizabeth Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 214-48-3945		17 INFORMANT Rfd. 1 Box 154 Mr. James O. Frey, Boonsboro, Md. 21713					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>ABC, OBS</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 8b, PART 1, OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>11.5</u> 19 <u>86</u> to <u>10.11</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9.24</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE <u>Vasant Datta, MD</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <u>10.12.87</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, MD			22e ADDRESS 334 MILL ST. HAGERSTOWN, MD 21740						
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE 10-14-87		23c NAME OF CEMETERY OR CREMATORY Bakersville Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Bakersville, Wash. Co., Md.			
24 FUNERAL DIRECTOR NAME John H. Bast, Jr. Boonsboro, Md. 21713				25a DATE REC'D. BY REGISTRAR OCT 15 1987		25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Pondale</u>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

088828 Oct 1941

Female

White

June 1, 1898

52

Barlowe, W. H. ... U. S. ... Washington

Washington

Washington

Box 124

Albany

Kelly

1941

241-60-1941 Mr. James O. Kelly, Bonanza, N. Y.

10

10-11-41

Serial

10-11-41

Bonanza, N. Y.

Albany, N. Y.

John ... Bonanza, N. Y.

Oct 15 1941

Albany, N. Y.

070124 OCT 29 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF ESTD DEATH MATED			2b DATE MONTH DAY YEAR			2c HOUR MIN		
Gregory L. Church			10 10 19 87			10 10 19 87			8:15 PM		
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) (LAST BIRTHDAY)	7a IF UNDER 1 YR MONTHS DAYS	7b IF UNDER 24 HRS HOURS MIN	7c DATE PRONOUNCED DEAD			7d HOUR MIN		
M	WHITE	12-22-1965	21 YRS			10 18 19 87			8:15 PM		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
W. VA.			U.S.A.						Washington County MD		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital (DOA)			CONSTRUCTION					
13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE			13b COUNTY			13c CITY OR TOWN			13d STREET ADDRESS		
W. VA.						Buckley Springs			WASHINGTON ST		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.		
BURL CHURCH			HELEN KEISTER			No			235-96-7978		
17 INFORMANT			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Charles Butcher Rt #1 Box 77B			PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								

MEDICAL CERTIFICATION

20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR xxxx 10 10 19 87		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)		
Subject recovered from water		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
water	Rt. 522	Hancock W. VA.
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (METHOD)		
BURIAL		
23b DATE 10-24-87		
23c NAME OF CEMETERY OR CREMATORY BUSH CEM.		
23d LOCATION CITY OR TOWN COUNTY STATE		
LEWIS G. W. VA.		
24 FUNERAL DIRECTOR NAME ADDRESS		
SHARDA F. H. 2829 HUDSON ST.		
25a DATE REC'D BY REGISTRAR		
OCT 26 1987		
25b REGISTRAR'S SIGNATURE		

ACTUAL
SIGNATURE

EXAMINER'S NAME
(TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

DATE SPECIFY
Assistant MEDICAL EXAMINER

DATE SIGNED 10/19/87

Balto.MD.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100121 12/05/01

DATE 12-05-01

W. 12

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12-05-01

20% COTTON FIBER

WALKER



12-05-01



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70612 NOV -3 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) HENRY A. CONWAY			2a DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 10 26 19 87			2b HOUR M 8:40	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR July 21, 1923	6 AGE (IN YEARS) (LAST BIRTHDAY) 64 YRS	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 28 19 87	2d HOUR M 8:40
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD	
10 CITY OR TOWN OF DEATH Rohrersville		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Schoolhouse Rd., P.O. Box 51			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Captain		12b KIND OF BUSINESS Merchant Marine
13a STATE Md.		13b COUNTY Wash.	13c CITY OR TOWN Rohrersville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS P.O. Box 51 Schoolhouse Rd. 21779		
14 FATHER'S NAME FIRST MIDDLE LAST Henry G. Conway			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ila Sutton				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b SOCIAL SECURITY NO. WW 11 150-14-5612		17 INFORMANT ADDRESS Mr. Robert E. Babington Keedysville Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10-26-19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self-inflicted.			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f LOCATION STREET CITY OR TOWN COUNTY STATE Schoolhouse Rd., P.O. Box 51, Washington, MD			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy Chief		M.D.		DATE SIGNED 10-28-87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct. 29 87		23c NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash., Md.	
24 FUNERAL HOME NAME Dennis K. Davis Funeral Home				25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMM - 17
(VR A15 ME (5))

DATE: 11/11/50

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

NY 100-100000-1

NY 100-100000-1

NY 100-100000-1

NY 100-100000-1



NY 100-100000-1

NY 100-100000-1

NY 100-100000-1

NY 100-100000-1

NY 100-100000-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		2a DECEASED NAME (TYPE OR PRINT)		2b DATE OF DEATH MONTH DAY YEAR		2c HOUR	
1a DECEASED NAME (TYPE OR PRINT)		1b DECEASED NAME (TYPE OR PRINT)		1c DECEASED NAME (TYPE OR PRINT)		1d DECEASED NAME (TYPE OR PRINT)	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO	
17 INFORMANT		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
19c DATE OF OPERATION		19d CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED	
21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (his hospital) attended the deceased from 19 to 19 that (I) (we) lost		22b SIGNATURE	
22c DATE SIGNED		22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f DATE SIGNED	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME		25 DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		25c REGISTRAR'S SIGNATURE	

FUNDAL DIRECTOR

GERALD N. MINNICH

305 N. POTOMAC STREET
HAGERSTOWN, MARYLAND

OCT 30 1987

Jillie Gordon-Parker

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

070854

Item 1, Item 6634 12-1-87 dw

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE BLANCH LAST DONEGAN			2a DATE OF DEATH MONTH 10 DAY 29 YEAR 87		2b HOUR 6:25p.m.		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH 9 DAY 28 YEAR 1891		6 AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	
7a BIRTHPLACE MARYLAND		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10 CITY OR TOWN OF DEATH WILLIAMSPORT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOMWOOD RETIREMENT CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ALTERATIONS		12b KIND OF BUSINESS OR INDUSTRY RETAIL STORE	
13a STATE MARYLAND		13b COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME THOMAS		15 MOTHER'S MAIDEN NAME MARGARET MURRAY		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 212-14-7647	
17 INFORMANT C. PATRICK DONEGAN		ADDRESS 101 QUAKER CREEK DR. HANOCK, Md.		18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BILATERAL PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASPIRATION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CEROBRAL INFARCTION</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART I OR PART II)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) this hospital attended the deceased from <u>3/1/85</u> 19 <u>85</u> to <u>10/29</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>10/29</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>[Signature]</u>				22c DATE SIGNED <u>10/30/87</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Stephen E. Metzner				22e ADDRESS 1825 Howell Road			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 11-2-87		23c NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH. MD.	
24 FUNERAL DIRECTOR NAME GERALD N. MINNICH				25a DATE REC'D. BY REGISTRAR NOV 04 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

REPERMANE FORMER
REPERMANE FORMER

REPERMANE FORMER

2118 28 1074 13

Station - 1825 10201 1825 10201

069639 OCT

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SALLY Elizabeth DORAN			2a DATE OF DEATH MONTH DAY YEAR OCT. 20 '87		2b HOUR 5⁵⁵ A.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 5 25 1913		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN) New Jersey	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AVALON MANOR		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a STATE Maryland		13b COUNTY Washington	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Intile		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Unknown		13e STREET ADDRESS / ZIP CODE 11 South Walnut Street 21740	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 136-03-2933		17 INFORMANT ADDRESS Diana M. Hill 102 Planters Lane Keedysville, Maryland 21756	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE <i>[Signature]</i>	DEGREE	ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10-20-87
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. S. [Signature]		22e ADDRESS Rfd. 4 Box 7 Smithsburg Washington Maryland	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 10-20-87	23c NAME OF CEMETERY OR CREMATORY Smithsburg Crematory	23d LOCATION (CITY OR TOWN) COUNTY Smithsburg Washington Maryland
24 FUNERAL DIRECTOR NAME Bast Funeral Home Boonsboro, Maryland 21783		25a DATE REC'D. BY REGISTRAR OCT 23 1987	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use on the burial transit permit. This permit is required to remove the body from the place of death within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is injury or other traumatic event, the medical examiner should be notified.

000000 OCT 20 1951

11/20/51

New Jersey

U.S.A.

Department

Secretary

Washington, D.C.

Benjamin

Wells

to

10-20-51

James L. Hill

100 Pleasant Lane
New York 21, N.Y.



COTTON LIBER

10-20-51

Continuation

10-20-51

Smithsonian Institution

Washington, D.C.

OCT 20 1951

U.S. A. 304

James L. Hill, Secretary

070908 NOV 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 - STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
1b DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH		2b HOUR	
FLORENCE LILLIAN ELLIS		10 29 87		1:15 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	7b HOUR	
Female	White	August 2, 1905	82		
7a BIRTHPLACE	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	9 BALTIMORE CITY OR COUNTY OF DEATH		
Chalauca, N. Y.	U. S. A.	NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Washington MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a USUAL OCCUPATION	12b KIND OF BUSINESS OR INDUSTRY		
Boonsboro	Reeders Memorial Home	Housewife	Own Home		
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE	
Virginia	Warren	Front Royal	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	P. O. Box 523	22630
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME				
John	Lillian				
16a WAS DECEASED EVER IN U.S. ARMED FORCES?	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS		
No	579-20-3632	Mrs. Lee Mangiene,	Front Royal, Va. 22630		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) Cardio pulmonary arrest					few min
DUE TO OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					
(b) Pneumonitis					2-3 days
DUE TO OR AS A CONSEQUENCE OF					
(c) ABCVD					m
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
OAS, Renal operation, CVA, Parkinson's disease					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY	21c HOW INJURY OCCURRED			
	HOUR A.M. MONTH DAY YEAR	ENTER NATURE OF INJURY IN PART 1 OR PART 2			
	P.M. 19				
21d INJURY OCCURRED	21e PLACE OF INJURY	21f LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	(AT HOME STREET FACTORY OFFICE FARM ETC.)	STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 11.5 19.87 to 10.29 19.87 that (I) (we) last saw the deceased alive on 10.29 19.87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death					
22b SIGNATURE		DEGREE	22c DATE SIGNED		
Vasant Datta		MD	10.29.87		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
VASANT DATTA					
22e ADDRESS					
334 MILL ST, HAGERSTOWN, MD 2174.					
23a BURIAL, CREMATION, REMOVAL	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION		
Removal- Burial	10-29-87	Prospect Hill Cem.	Front Royal, Warren Co., Va.		
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Bast Funeral Home		NOV 04 1987		Julia Davidson-Randall	
John H. Bast, Jr. Boonsboro, Md. 21713					

069784 OCT 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Lucille

NMN

ETCHISON

2a DATE OF DEATH MONTH DAY YEAR

October 16, 1987

2b HOUR

8:20P.M.

3 SEX

female

4 RACE

white

5 DATE OF BIRTH

April 21, 1894

6 AGE (IN YEARS LAST BIRTHDAY)

93

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

West Virginia

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Washington

MD

10 CITY OR TOWN OF DEATH

Boonsboro

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Fahrney Keedy Memorial Home

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

musician

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Washington

13c CITY OR TOWN

Hagerstown

13d INSIDE CITY LIMITS?

YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE

206 North Colonial Dr. 21740

14 FATHER'S NAME

William

MIDDLE

E.

LAST

Shannon

15 MOTHER'S MAIDEN NAME

Maude

MIDDLE

Palmer

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

no

16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)

577-48-3387

17 INFORMANT

ADDRESS

Mr. Bruce Etchison, Fayetteville, PA.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the
underlying cause last

(b) Chronic obstructive pulmonary disease

DUE TO, OR AS A CONSEQUENCE OF

(c) Cerebrovascular accident

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____ that (I) (we) last
saw the deceased alive on _____, 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c DATE SIGNED

10/17/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

ABDUL WAHEED MD

22e ADDRESS

1610 - OAK HILL AVE. HAGERSTOWN - MD.

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

burial

23b DATE

Oct. 17, 1987

23c NAME OF CEMETERY OR CREMATORY

Smithsburg Crematory

23d LOCATION

Smithsburg, Wash., Maryland

24 FUNERAL DIRECTOR MINNICH FUNERAL HOME

415 East Wilson Blvd., Hagerstown, Maryland

25a DATE REC'D. BY REGISTRAR

OCT 26 1987

25b REGISTRAR'S SIGNATURE

8 3 0 8 2 3

069678 OCT 26 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG NO

FOR
 STATE
 REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) REBECCA Virginia FEASTER				2a DATE OF DEATH MONTH DAY YEAR 10 17 87				2b HOUR 1051 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 19, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 97 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN 0 0 0 0	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Homemaker	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Frederick 13c CITY OR TOWN Knoxville				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Mountain Road / 21758			
14 FATHER'S NAME FIRST MIDDLE LAST Walter ? Henry				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth ? ?					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO None		17 INFORMANT ADDRESS 620 Brunswick St. Chester O. Feaster - Brunswick, MD 21716					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few min	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Probable A2 MI								1 day	
DUE TO, OR AS A CONSEQUENCE OF (c) ABCO								2 hr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 ChF, Aortic Aneurysm									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 1986 to 10.17.87 that (I) (we) last saw the deceased alive on 10.16.87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE V. J. Datta				DEGREE MD				22c DATE SIGNED 10.17.87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, MD				22e ADDRESS 334 MILL ST HAGERSTOWN, MD 21740					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/20/87		23c NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Knoxville, Frederick, MD.			
24 FUNERAL DIRECTOR NAME ADDRESS John T. Williams Funeral Home Brunswick, MD.				25a DATE REC'D BY REGISTRAR OCT 21 1987		25b REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
 (VRA 15. 4)

18315 5/230

068954 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30624

1 DECEASED NAME (TYPE OR PRINT) Cleo m Flook			2a DATE OF DEATH MONTH DAY YEAR 10 14 87		2b HOUR 6:10 PM
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR 12 23 1895		6 AGE (IN YEARS (LAST BIRTHDAY)) 92 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rodgersville, Tenn.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD			10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a STATE Maryland			13b COUNTY Washington	13c CITY OR TOWN Keedysville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Charles Webster Pryor			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Teresa Miller		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 219-20-2597		17 INFORMANT Mr. Charles L. Flook, Keedysville, Md. 21756	
18 CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 10/14/87 to 10/14/87 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE R.L. Kugler		DEGREE MD		22c DATE SIGNED 10/14/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) R.L. Kugler		22e ADDRESS Geeting Lane, Keedysville, Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-17-87		23c NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
23d LOCATION (CITY OR TOWN COUNTY STATE) Keedysville, Wash. Co., Md.		23e DATE REC'D BY REGISTRAR OCT 19 1987			
24 FUNERAL DIRECTOR NAME John H. Bast, Jr. Bast Funeral Home, Boonsboro, Md. 21713		25 REGISTRAR'S SIGNATURE J. Gordon Rindick			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach this certificate to the funeral director's page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Charlotte Mae FREEMAN		2a. DATE OF DEATH MONTH DAY YEAR 10 14 87		2b. HOUR 8:55 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 1, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington KROOKER County MD	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Lutheran Village		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Emmitsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Horatio P. Freeman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madeline Frailey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-14-9930	
17. INFORMANT Ruth M. Freeman		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency/Failure</u> DUE TO, OR AS A CONSEQUENCE OF b) <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>Down Syndrome</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		19. STREET ADDRESS / ZIP CODE E. Main St. 21727		20. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD 21210	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)		22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		30. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		31. LOCATION STREET CITY OR TOWN COUNTY STATE		32. I certify that I (this hospital) attended the deceased from <u>12 July 1989</u> to <u>14 Oct 1989</u> that I (we) last saw the deceased alive on <u>14 Oct 1989</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)	
33. SIGNATURE <u>[Signature]</u>		34. DEGREE		35. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		36. DATE SIGNED 15 Oct 1987	
37. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. H. Fender		38. ADDRESS 138 E. Antietam St., Hagerstown MD		39. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		40. DATE 17 OCT 87	
41. NAME OF CEMETERY OR CREMATORY Emmitsburg Memorial		42. LOCATION CITY OR TOWN COUNTY STATE Emmitsburg Frederick MD		43. FUNERAL DIRECTOR Skiles Funeral Home, Emmitsburg, MD 21727		44. DATE REC'D. BY REGISTRAR OCT 19 1987	
45. REGISTRAR'S SIGNATURE <u>[Signature]</u>		46. REGISTRAR'S NAME Julia Swickard-Rudner		47. REGISTRAR'S ADDRESS		48. REGISTRAR'S PHONE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or contacted.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Joseph		LAST FRISENDA		2a. DATE OF DEATH MONTH DAY YEAR Oct. 18, 1987		2b. HOUR 9:25 A.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 29, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) credit manager		12b. KIND OF BUSINESS OR INDUSTRY food dist.	
13a. STATE Maryland		13b. COUNTY Hagerstown		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Eponomondo Frisenda		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teresa Napolitano		13e. STREET ADDRESS / ZIP CODE 606 Shore Dr. 21085					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 081-03-5694		17. INFORMANT ADDRESS Vincent Tantillo, Hagerstown, Md.					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Severe generalized atherosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Diabetic Mellitus Type II</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe peripheral vascular disease with gangrene of feet</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> , 19 <u>87</u> , to <u>10/18</u> , 19 <u>87</u> that (I) <u>did</u> did not saw the deceased alive on <u>10/17</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If I <u>did not</u> view the body after death.)									
22b. SIGNATURE <u>John R. Marsh, M.D.</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Marsh, M.D.				22e. ADDRESS 237 N. Potomac St. HAGERSTOWN, MD 21784					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Oct. 20, 1987		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a. DATE REC'D. BY REGISTRAR OCT 22 1987		25b. REGISTRAR'S SIGNATURE <u>John R. Marsh</u>	

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FOOTNOTES

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Burgess Elmer Green			2a DATE OF DEATH MONTH DAY YEAR 10 25 87			2b HOUR 5:15a M					
3 SEX M		4 RACE B		5 DATE OF BIRTH MONTH DAY YEAR 03 9 1909		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7b HOUR 5:15a M			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD					
10 CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick Yard		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md			13b COUNTY Frederick		13c CITY OR TOWN Adamstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Rt 1 21710		
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Green			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Green			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N.				16b SOCIAL SECURITY NO 577 16 1920	
17 INFORMANT Barbara King			17 ADDRESS Silver Spring, Md			17b ADDRESS 1608 Lockwood Drive					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>esophageal carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b; PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 19 to 10/25 19 87 that (I) (we) last saw the deceased alive on 10/13 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>R. Guendet</i>			DEGREE M.D.			22c DATE SIGNED 10/26/87					
22d PHYSICIAN'S NAME (TYPE OR PRINT) R. GUENDET M.D.			22e ADDRESS P.O. Box 246 KEEDYSVILLE, MD 21756								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10 28 1987		23c NAME OF CEMETERY OR CREMATORY Fairview		23d LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md				
24 FUNERAL DIRECTOR NAME C.E. Hicks, 111 1922 Forest Drive Anna Md						25a DATE REC'D BY REGISTRAR OCT 29 1987		25b REGISTRAR SIGNATURE <i>Julia Deaton-Randall</i>			

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Laura May GREEN			2a DATE OF DEATH MONTH DAY YEAR 10- 11- 87			2b HOUR 11:40pm			
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH - Washington MD			
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ravenwood Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurse		12b KIND OF BUSINESS OR INDUSTRY private duty	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 43 Summerlin Dr. 21740	
14 FATHER'S NAME FIRST MIDDLE LAST William S. Green			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Birney						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS Donald Green, 43 Summerlin Dr., Hagerstown, Md.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute CVA</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Accv</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a DATE OF OPERATION <u>035</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>W. B. KANA M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-12-87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS 1933 Va. Ave. Hagerstown, Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Oct. 14, 1987		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24 FUNERAL DIRECTOR (NAME) MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a DATE REC'D BY REGISTRAR OCT 16 1987		25b REGISTRAR'S SIGNATURE <u>Julia Dendron Rader</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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DAVID WALKER



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 0 5 2 7

1 DECEASED NAME (TYPE OR PRINT) Edward Joseph GREGG		2a DATE OF DEATH MONTH DAY YEAR 10-31-87		2b HOUR 6:45 P.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 21, 1915	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE W. Va.		13b COUNTY Berkeley		13c CITY OR TOWN Falling Waters	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph - Gregg		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	
16b SOCIAL SECURITY NO. WW 11		17 INFORMANT Kathleen L. Gregg, Hagerstown, Md.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Gregg Paul		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/31/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WATKINS		22e ADDRESS 1610 - OAKHILL AVE HAGERSTOWN MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Nov. 2, 1987		23c NAME OF CEMETERY OR CREMATORY Smithsburg Crematory	
23d LOCATION CITY OR TOWN Smithsburg, Wash., Md.		23e COUNTY Wash., Md.			
24 FUNERAL DIRECTOR NAME Davis Funeral Home, Smithsburg, Md., 21783		25a DATE REC'D. BY REGISTRAR NOV 06 1987		25b REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH 1650M (1/81)
(VRA 15, 4)

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070147 OCT 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAVIS Virginia GROVE			2a DATE OF DEATH MONTH DAY YEAR October 22, 1987		2b HOUR M AM
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR May 9, 1931		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 00 00 00 00
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waitress		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Washington	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 70 Madison Avenue 21740
14 FATHER'S NAME FIRST MIDDLE LAST Ernst R. Socks		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Shoemaker			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 215-26-8641		17 INFORMANT ADDRESS Mr. Hillard F. Grove, Sr., Hagerstown, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC TUBERCULOSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington Maryland	
22a I certify that (a) (this hospital) attended the deceased from April 29 1985 to Oct. 22 1987 , that (b) (we) last saw the deceased alive on Oct. 12 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) interview the next of kin after death.					
22b SIGNATURE Stephen E. Metzner, MD		DEGREE MD		22c DATE SIGNED 10/23/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN E. METZNER, MD		22e ADDRESS 1825 Howell Rd. Hagerstown			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b DATE Oct. 26, 1987	23c NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740				25a DATE REC'D. BY REGISTRAR OCT 28 1987	25b REGISTRAR'S SIGNATURE <i>John L. ...</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

Respectfully,
 (Signature)

For: [illegible]
 [illegible]
 [illegible]
 [illegible]

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) SYLVIA L GROVE			2a DATE OF DEATH MONTH DAY YEAR OCT. 3, 1987		2b HOUR 7:54AM	
3 SEX FEM.		4 RACE CAUC.		5 DATE OF BIRTH MONTH DAY YEAR FEB 22 1912		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hosp.		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co., MD		
13a STATE Pa.		13b COUNTY Franklin		13c CITY OR TOWN Mercersburg		
14 FATHER'S NAME FIRST MIDDLE LAST Asbury Pine		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Shives		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 204-01-5808		17 INFORMANT ADDRESS Mrs. Alma Martin Mercersburg, Pa. 9385 Royer Rd. 17836		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INCREASED INTRACRANIAL PRESSURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBRAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) OCCLUSION RIGHT INTERNAL CAROTID ARTERY PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes Mellitus Type II HBP.						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (a) (this hospital) attended the deceased from 9-30 19 87 to 10-3 19 87 that (b) (we) last saw the deceased alive on 10-3 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.						
22b SIGNATURE Edward Byrd M.D.		DEGREE		22c DATE SIGNED 3 Oct. 87		
22d PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD BYRD, M.D.		22e ADDRESS 1198 KENLY AVE. HAGERSTOWN, MD. 21740				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/6/87		23c NAME OF CEMETERY OR CREMATORY Fairview Cem. Mercersburg Franklin Pa.		
24 FUNERAL DIRECTOR NAME A. H. Linger		ADDRESS 17236 Mercersburg, Pa.		25a DATE REC'D BY REGISTRAR OCT 08 1987		
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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DHMH 16 60M 7 84
(VRA 15, 4)

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068662 OCT 15 1987

FOR
STATE
REGISTRAR

Thelma R. Gutkaska

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thelma R. Gutkaska			2a. DATE OF DEATH MONTH DAY YEAR 10-10-87			2b. HOUR 5:15 PM	
3. SEX Female		4. RACE CAUS.		5. DATE OF BIRTH MONTH DAY YEAR March 25, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Balto City,	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Roehmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie S. Leinebach		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO --			
16b. SOCIAL SECURITY NO. 214-14-3388		17. INFORMANT John W. Roehmer, Nephew,		17b. ADDRESS 11718 Hillside Rd, Kingsville, Md. 21087			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b. PART FOR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 87 to 10 10 19 87 that (I) (we) last saw the deceased alive on 10 10 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Abdul Wahed		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAHEED		22e. ADDRESS 1610 Oak Hill Ave. Hagerstown, MD					

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/12/87		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.	
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 21236		9705 Belair Road		25a. DATE REC'D BY REGISTRAR OCT 14 1987		25b. REGISTRAR'S SIGNATURE Julia Darden-Randall	

069778

OCT 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30054

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah Sleasman HARDING SARAH HARDING				2a DATE OF DEATH MONTH DAY YEAR 10 - 11 - 87		2b HOUR M	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR April 10, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor	
12b KIND OF BUSINESS OR INDUSTRY Store							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY Wash. 13c CITY OR TOWN Smithsburg				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Rt 3 Box 26 21783	
14 FATHER'S NAME FIRST MIDDLE LAST Walter B. Sleasman				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Ross			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO 214-09-6419		17 INFORMANT ADDRESS Mr. Donald M. Harding Smithsburg, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>less than one hour</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Diabetes Mellitus, type II</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>for 6 years</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Walter E. Monahan</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 14, 1987		23c NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d LOCATION Smithsburg, Wash., Md. STATE	
24 FUNERAL DIRECTOR Davis Funeral Home				25a DATE REC'D BY REGISTRAR Oct 28 1987		25b REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (Type or Print)		FIRST MIDDLE LAST CLAUDE W Woodrow		2a. DATE OF DEATH MONTH DAY YEAR October 25 87		2b. HOUR 6 30 P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR October 31, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) head custodian		12b. KIND OF BUSINESS OR INDUSTRY Board of Educ.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles T. Harmison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence May Kidney		13e. STREET ADDRESS 220 N. Locust Street 21740			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-05-2798		17. INFORMANT ADDRESS Myrtle L. Harmison, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>TERMINAL DISEASE OF Lung & AC</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis to bone</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 2</u> , 19 <u>87</u> , to <u>25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>E. R. Landis</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-26-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. R. Landis</u>		22e. ADDRESS <u>382 N. Locust St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Oct. 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE RECEIVED BY REGISTRAR OCT 28 1987			
				25b. REGISTRAR'S SIGNATURE			

07 50 18 28 70 05

170394 NOV-28

FOR
STATE
REGISTRAR

FLORINE LORENE HENSON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FLORINE LORENE HENSON			2a DATE OF DEATH MONTH DAY YEAR October 25 87			2b HOUR 2:55 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH July 27, 1922		6 AGE (IN YEARS LAST BIRTHDAY) 65		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK, OR MOST OF WORKING LIFE) Cleaning Lady		12b KIND OF BUSINESS OR INDUSTRY YMCA	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Washington 13c CITY OR TOWN Hagerstown					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 64 West Franklin Street 21740		
14 FATHER'S NAME FIRST MIDDLE LAST George David Orye					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Susan Rodgers				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217-18-7698		17 INFORMANT LC. David Dean		64 West Franklin St-reet Hagerstown, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency / Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia bacterial and carcinoma lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: multiple myeloma - Diabetes mellitus - Sepsis									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 18 March 1982 to 25 Oct. 1987 , that (I) (we) last saw the deceased alive on 29 Oct 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Wm. N. Fender MD					DEGREE MD		22c DATE SIGNED 26 Oct 1987		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d PHYSICIAN'S NAME (TYPE OR PRINT) Wm. N. Fender					22e ADDRESS 138 E. Antietam St., Hagerstown MD				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10-28-87		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Maryland		
24 FUNERAL DIRECTOR NAME Andrew K. Coffman Funeral Home, Inc.					ADDRESS Hagerstown, Md.		25 DATE REC'D. BY REGISTRAR OCT 30 1987		
					26 REGISTRAR'S SIGNATURE Julia Dutton Fender				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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BP _____

1033 / 10-2-1

1033 / 10-2-1

1033 / 10-2-1

067764 OCT-78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST: <u>Glen</u> MIDDLE: <u>S.</u> LAST: <u>Higdon</u>		2a DATE OF DEATH MONTH: <u>Oct.</u> DAY: <u>20</u> YEAR: <u>1987</u>		2b HOUR: <u>6 P.M.</u>	
3 SEX <u>Male</u>		4 RACE <u>White</u>		5 DATE OF BIRTH MONTH: <u>Dec.</u> DAY: <u>24</u> YEAR: <u>1933</u>	
6 AGE (IN YEARS, LAST BIRTHDAY) <u>53</u>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Yarrowsburg, Md.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.		10 CITY OR TOWN OF DEATH <u>Hagerstown</u>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Maintenance</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Apt. Building</u>	
13a STATE <u>Maryland</u>		13b COUNTY <u>Washington</u>		13c CITY OR TOWN <u>Hagerstown</u>	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <u>1750 Garden Lane 21740</u>			
14 FATHER'S NAME FIRST: <u>Bruce</u> MIDDLE: <u>Leonard</u> LAST: <u>Higdon</u>		15 MOTHER'S MAIDEN NAME FIRST: <u>Mildred</u> MIDDLE: <u>Spencer</u> LAST: <u>Spencer</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <u>No</u>		16b SOCIAL SECURITY NO <u>217-30-6593</u>		17 INFORMANT <u>Mrs. Arys A. Higdon, Hagerstown, Md.</u>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastatic Ca of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few mrs</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>about 1949</u> to <u>January 1987</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>For Dr. William Lesh</u>		DEGREE <u>MD</u>		22c DATE SIGNED <u>10.3.87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>FOR DR WILLIAM LESH</u>		22e ADDRESS <u>334 MILL ST. HAGERSTOWN, MD 21740</u>			
23a BURIAL, CREMATION, REMOVAL <u>Cremation</u>		23b DATE <u>10-3-87</u>		23c NAME OF CEMETERY OR CREMATORY <u>Smithsburg Crematory</u>	
23d LOCATION CITY OR TOWN COUNTY STATE <u>Smithsburg, Wash. Co., Md.</u>		24 FUNERAL DIRECTOR NAME: <u>Bast Funeral Home</u> John H. Bast, Jr. Boonsboro, Md. 21713			
25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE <u>John Davidson</u>	

MEDICAL CERTIFICATION

BP

DHMH 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) Lester E. Hines			2a DATE OF DEATH MONTH DAY YEAR October 1, 1987		2b HOUR 10:30P^M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 23, 1897		
6 AGE (IN YEARS LAST BIRTHDAY) 90		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rohrersville, Md.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington		10 CITY OR TOWN OF DEATH Hagerstown		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b KIND OF BUSINESS OR INDUSTRY Milling Co.		
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Keedysville		
14 FATHER'S NAME FIRST MIDDLE LAST George Hines		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ardella Poffenberger		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b SOCIAL SECURITY NO. 214-03-6265		17 INFORMANT ADDRESS Mrs. Pauline Lowe, Keedysville, Md. 21756		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Central nervous system hypoxemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>aspiration of vomitus and cerebral hypoxia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>chronic organic brain syndrome</u>						
19a DATE OF OPERATION <u>9-29-87</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Respiratory Arrest</u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (this hospital) attended the deceased from <u>9-29-87</u> to <u>10-1-87</u> that (I) (we) last saw the deceased alive on <u>10-1-87</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10-2-87</u>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) John H. Bast, Jr.		22e ADDRESS Boonsboro, Md. 21713		23a BURIAL, CREMATION, REMOVAL CLAY Burial		
23b DATE 10-5-87		23c NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Keedysville, Wash. Co., Md.		
24 FUNERAL DIRECTOR NAME John H. Bast, Jr.		25a DATE REC'D. BY REGISTRAR OCT 06 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070395 NOV-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Lou HOFFMAN			2a DATE OF DEATH MONTH DAY YEAR October 24, 1987		2b HOUR 2:06P_M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 7, 1907		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		
10 CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b KIND OF BUSINESS OR INDUSTRY Electric Co.		13a STREET ADDRESS / ZIP CODE 856 Rolling Road 21740		
13b STATE Maryland		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST David Miller		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Frush		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b SOCIAL SECURITY NO 214-01-5955		17 INFORMANT Harold H. Hoffman		ADDRESS 943 Forest Drive Hagerstown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a ALCOHOLIC LIVER DISEASE. HYPERTENSION						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						
22b PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN E. METZNER, MD		DEGREE MD		22c DATE SIGNED 10/25/87		
22d ADDRESS 1825 Howell Rd.		23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				
23b DATE 10-26-87		23c NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium		23d LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Washington, Md.		
24 FUNERAL DIRECTOR NAME Andrew K. Coffman Funeral Home, Inc.		ADDRESS Hagerstown, Md.		DATE RECEIVED BY REGISTRAR OCT 30 1987		
25 REGISTRAR'S SIGNATURE <i>John D. ...</i>						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

• • •

067808 OCT-7-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Elsie Jane Hoopengardner			2a DATE OF DEATH MONTH DAY YEAR 10-01-87		2b HOUR 6:20 P.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 12 03 1917	6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
8a BIRTHPLACE (STATE OR FOREIGN) Mckeesport	8b CITIZEN OF WHAT COUNTRY? United States	9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD		
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b KIND OF BUSINESS OR INDUSTRY Londontown	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE PA 13c COUNTY Fulton 13d CITY OR TOWN Warfordsburg			13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13f STREET ADDRESS / ZIP CODE Rt #2 17267	
14 FATHER'S NAME FIRST MIDDLE LAST Raymond Burns		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Creek			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unknown		16b SOCIAL SECURITY NO 213-24-9200	17 INFORMANT Terry J. True ADDRESS Rt #2 Box 625 Warfordsburg, PA 17267		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Abdul Wahed		DEGREE MD		22c DATE SIGNED 10/1/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAHEED MD		22e ADDRESS 1610 OAKHILL AVE HAGERSTOWN MD			
23a BURIAL, CREMATION, REMOVAL (TYPE) burial	23b DATE 10/04/87	23c NAME OF CEMETERY OR CREMATORY Buck Valley Christian	23d LOCATION CITY OR TOWN COUNTY STATE Warfordsburg Fulton PA		
24 FUNERAL DIRECTOR Richard J. Drove		25a DATE REC'D BY REGISTRAR OCT 05 1987	25b REGISTRAR'S SIGNATURE Handwritten Signature		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

069557 OCT 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alberta Ardell Horowitz</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 18 87</i>		2b. HOUR <i>6:30 AM</i>	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 30, 1923</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE <i>Route 9, Box 143 21740</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Russell Wilson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edna Mae Hankey</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>217-12-2627</i>		17. INFORMANT ADDRESS <i>Mr. Isidore Horowitz, Hagerstown, MD.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Embolus</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Adenocarcinoma of lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Severe Organic Heart Disease</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <i>1985</i> 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <i>Aug 19 87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Mary E. Money MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/15/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mary E. Money MD</i>		22e. ADDRESS <i>1708 Oak Hill Ave, Hagerstown, Md 21740</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>Oct. 21, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740</i>				
25a. DATE REC'D. BY REGISTRAR <i>OCT 22 1987</i>		25b. REGISTRAR'S SIGNATURE <i>The Registrar</i>				

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

020227 011313

020227 011313

068193 OCT-9 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MARTH A		MIDDLE H		LAST HOWELL		2a DATE KNOWN OF DEATH		X MONTH DAY YEAR 10-1 1987		2b HOUR P 4:35	
3 SEX Female	4 RACE Negro	5 DATE OF BIRTH MONTH DAY YEAR 11 01 99		6 AGE (IN YEARS) LAST BIRTHDAY 87 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c DATE PRONOUNCED DEAD 10-1 1987		2d HOUR P 4:35	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD							
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY							
13a STATE Md.		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 66 W. North Street 21740					
14 FATHER'S NAME FIRST Hubert MIDDLE MNM LAST Howell		15 MOTHER'S MAIDEN NAME FIRST Martha MIDDLE MNM LAST Bell											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217-32-5389		17 INFORMANT ADDRESS Walter Davis, 661 Pennsylvania Ave.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 887 IMMEDIATE CAUSE (a) HYPERTENSIVE ASCVD - 402 DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS - 250 DUE TO, OR AS A CONSEQUENCE OF (c) SENILE PSYCHOSIS - 290												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I EX. RT+HIP, INFECTED													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		George Milic M.D.		TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER		DATE SIGNED 10-1-87							
EXAMINER'S NAME (TYPE OR PRINT)		GEORGE MILIC, M.D.		ADDRESS HAGERSTOWN - MD - 21740									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-6-87		23c NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Pk.		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.							
24 FUNERAL DIRECTOR NAME		L. Davis Smithburg, Md.		25a DATE REC'D BY REGISTRAR 21783 OCT 06 1987		25b REGISTRAR'S SIGNATURE							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PW-3" RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07-84
25M

BP

DHMH 17
(VR A15 ME (5))



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070848 NOV

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roy George G. Hudson			2a DATE OF DEATH MONTH DAY YEAR 10-30-1987		2b HOUR 5:15 P.M.
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR December 15, 1909	6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor	12b KIND OF BUSINESS OR INDUSTRY aircraft	
13a STATE Maryland			13b COUNTY Washington	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Richard Hudson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Scott		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 209-09-4846		17 INFORMANT ADDRESS Mrs. Carolyn S. Hudson, Hagerstown, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>25 years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Carcinoma of esophagus</u>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>Jan 19 84</u> to <u>Oct 30 19 87</u> that (I) (we) <u>did</u> saw the deceased alive on <u>10/30 19 87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I/we)</u> (did not) view the body after death.					
22b SIGNATURE <u>Richard E. Smith, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/31/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard E. Smith, M.D.</u>		22e ADDRESS <u>1708 Oak Hill Ave, Hagerstown, Md. 21740</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Nov. 3, 1987	23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland
24 FUNERAL DIRECTOR NAME 415 East Wilson Blvd., Hagerstown, MD. 21740		MINNICH FUNERAL HOME ADDRESS		25a DATE REC'D BY REGISTRAR NOV 04 1987	
				25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070049 101-201

FOR COLLECTION PURPOSE

RECEIVED

EX-100-100000

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30644

1- DECEASED NAME FIRST MIDDLE LAST Lloyd William Jones			2a DATE KNOWN OF DEATH MONTH DAY YEAR 10 24 1987		2b HOUR M 11:10
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1910	6 AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH Washington County		10 CITY OR TOWN OF DEATH Knoxville			
11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19516 Garret Mills Rd.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b KIND OF BUSINESS OR INDUSTRY Manuf. Co.	
13a STATE Maryland		13b COUNTY Washington	13c CITY OR TOWN Knoxville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET ADDRESS 19516 Garretts Mill Road		14 FATHER'S NAME FIRST MIDDLE LAST Edward Fernandar Jones			
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Ann Clipp		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b SOCIAL SECURITY NO. 236-03-0540		17 INFORMANT ADDRESS 210 S. Main St. Donald E. Jones - Boonsboro, MD 21713			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shotgun wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? BODY ONLY <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOURS MIN MONTH DAY YEAR P.M. 10 24 1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) self inflicted	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) shed/home		21f LOCATION CITY OR TOWN COUNTY STATE 19516 Garret Mills Rd, Knoxville, Wash, MD.	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		DATE SIGNED 10/25/87	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.		Balto.MD.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/28/87	23c NAME OF CEMETERY OR CREMATORY 000d Brethren Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brownsville, Wash., MD	
24 FUNERAL DIRECTOR NAME John T. Williams		ADDRESS Brunswick, MD.		25a DATE REC'D BY REGISTRAR NOV 04 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25MDHMH-17
(VV 415 ME (5))

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93814 100-001
2082-0011 11025

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mildred Carson Lay			2a. DATE OF DEATH MONTH DAY YEAR October 4, 1987		2b. HOUR M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1919		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD		
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Washington	13c CITY OR TOWN Hancock	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 110 Penna. Avenue 21750

14 FATHER'S NAME FIRST MIDDLE LAST George Carson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cordelia Smith	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213 18 9905	17 INFORMANT ADDRESS Bill Carson 125 Harrison Ave. B.S., W.Va. 25411	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cholecystitis of bile ducts</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatic metastasis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from <u>9-20</u> 19 <u>87</u> to <u>10-4</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b SIGNATURE <u>Rich. J. Harnack MD.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-5-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10/6/1987	23c NAME OF CEMETERY OR CREMATORY Amaranth Brethren	23d LOCATION CITY OR TOWN COUNTY STATE Warfordsburg, Fulton, Penna.
24 FUNERAL DIRECTOR NAME <u>Richard J. Harnack MD.</u>		25a DATE REC'D BY REGISTRAR OCT 15 1987	
ADDRESS <u>Hancock MD.</u>		25b REGISTRAR'S SIGNATURE <u>John D. Harnack</u>	

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OCT 15 1964

068955 OCT 20 1987

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) WILLIAM TEMPLETON LAYMAN			2a DATE OF DEATH MONTH DAY YEAR 10 12 87			2b HOUR 9:00 AM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 7 19 16		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD	
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1039 THE TERRACE		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN		12b KIND OF BUSINESS OR INDUSTRY MEDICAL	
13a STATE MARYLAND		13b COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 1039 THE TERRACE 21740		14 FATHER'S NAME FIRST MIDDLE LAST JACOB WALTER LAYMAN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA TEMPLETON		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW 2	
16b SOCIAL SECURITY NO. 220-44-9611		17 INFORMANT ROSALIE A. LAYMAN		17 ADDRESS SEE # 13		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA PROSTATE WITH WIDESPREAD BONE METASTASIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause or stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a DATE SIGNED OCT. 14, 1987		22b SIGNATURE Schwartz E. D. Ditto	
22c PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.		22d ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND 21740		22e DATE REC'D. BY REGISTRAR OCT 19 1987		22f REGISTRAR'S SIGNATURE J. A. Swinson-Penderson	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 10-13-87		23c NAME OF CEMETERY OR CREMATORY SMITHSBURG CREAMTORY		23d LOCATION CITY OR TOWN COUNTY STATE SMITHSBURG, MARYLAND	
24 FUNERAL DIRECTOR NAME GERALD N. MINNICH		305 N. POTOMAC ST. HAGERSTOWN, MARYLAND		25a DATE REC'D. BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE J. A. Swinson-Penderson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use on the burial transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for vital, cremation, or removal.

IMPORTANT: If item 21 is checked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

068236 OCT-987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herbert Lee Leatherman			2a DATE OF DEATH MONTH DAY YEAR October 1 87		2b HOUR 5.0 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR December 7, 1917		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN 69	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY Washington	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Clyde J. Leatherman		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vallie V. Whittington			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 214-09-0418		17 INFORMANT ADDRESS Vivian L. Leatherman 10 Richmond St., Hagerstown, Md. 21740	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Esophagus and DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Esophageal Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from May 5 19 87 to Oct 1 19 87 that (I) (we) last saw the deceased alive on Oct 1 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Sidney Moverstein		DEGREE MD		22c DATE SIGNED 10-2-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SIDNEY MOVERSTEIN		22e ADDRESS FUNKS WOOD MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE Oct. 2, 1987	23c NAME OF CEMETERY OR CREMATORY Smithsburg Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington Md.	
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		ADDRESS 415 E. Wilson Blvd. Hagerstown, Maryland 21740		25a DATE REC'D BY REGISTRAR OCT 8 1987	
		25b REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right. The names are: John Smith, James Brown, William Jones, and Robert Taylor. The addresses are: 123 Main Street, New York, NY; 456 Elm Street, Boston, MA; 789 Oak Street, Philadelphia, PA; and 101 Pine Street, San Francisco, CA.

Green, James, Esq.,
123 Main Street,
New York, N.Y.

V

2. The second part of the document is a letter. The letter is written in a cursive hand and is addressed to John Smith, Esq., 123 Main Street, New York, NY. The letter is dated January 1, 1850, and is signed by James Brown, Esq., 456 Elm Street, Boston, MA. The letter contains the following text: "Dear Sir, I have the honor to acknowledge the receipt of your letter of the 28th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration. I am, Sir, very respectfully,
Yours, James Brown, Esq."

070608 NOV-3

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARJORIE L (Louise) LEE			2a DATE OF DEATH MONTH DAY YEAR 10 25 87		2b HOUR 6:28 AM
3 SEX F	4 RACE BLACK	5 DATE OF BIRTH MONTH DAY YEAR 8 15 53		6 AGE (IN YEARS LAST BIRTHDAY) 35 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON CO.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASH. MD.	
10 CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WCHA HAGERSTOWN, MD		12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b COUNTY WASH.	13c CITY OR TOWN HAGERSTOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Leo Butler		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Hardy			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-52-2178		17 INFORMANT 22824 Aquasco Road Mildred Butler Aquasco, MD 20608	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Pulmonary fibrosis. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE J. N. H. L.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/25/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WAHEED LUN		22e ADDRESS 1610 - OAK HILL AVE. HAGERSTOWN, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 30 Oct 87	23c NAME OF CEMETERY OR CREMATORY Christ Church		23d LOCATION CITY OR TOWN COUNTY STATE Baden, P.G.Co., MD
24 FUNERAL DIRECTOR NAME Martell Adams, Aquasco Md		25a DATE REC'D. BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE Lisa Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

The first thing I noticed when I stepped
 out of the plane was the cold. It was a
 sharp contrast to the heat of the desert.
 The air was crisp and clear, and the
 mountains were visible in the distance.
 I had heard that the weather was good, but
 I didn't realize how good it would be.

The hotel was just what I needed. It was
 a simple, clean place with a comfortable
 bed. The staff was friendly and helpful,
 and the food was delicious. I had heard
 that the hotel was good, but I didn't realize
 how good it would be.

The next day, I went for a walk in the
 park. The trees were green and the
 flowers were in bloom. It was a beautiful
 sight, and I had heard that the park was
 good. I didn't realize how good it would be.

The trip was a great experience. I had
 heard that the trip was good, but I didn't
 realize how good it would be.

068308 OCT 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

30549

FOR
STATE
REGISTRAR

REG NO

1 DECEASED NAME (TYPE OR PRINT) Roger Levasseur Jr		2a DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR HOUR 10 3 1987 9⁰⁵ AM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 8, 1958	6 AGE (IN YEARS) (LAST BIRTHDAY) MONTH DAY YEAR 29 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.	
8 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b KIND OF BUSINESS OR INDUSTRY Car Dealer	
13a STATE Maryland		13b COUNTY Frederick	
13c CITY OR TOWN Ijamsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET ADDRESS 9949 Dr. Perry Rd/21754		14 FATHER'S NAME FIRST MIDDLE LAST Roger Levasseur, Sr.	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Pine		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR (UNKNOWN)) (IF YES, GIVE WAR OR DATES) No	
16b SOCIAL SECURITY NO. 220-74-1496		17 INFORMANT ADDRESS 9949 Dr. Perry Rd. Diana Barkdoll Ijamsville, MD 21754	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drug overdose - suicide E950 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last b) c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE Allen W Dittlo		TITLE (SPECIFY) Dept Assist	
EXAMINER'S NAME (TYPE OR PRINT) Allen W Dittlo MD		DATE SIGNED 9/5/87	
ADDRESS 1610 Oak Hill Ave Hagerstown MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 10-5-87	
23c NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium		23d LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington Maryland	
24a FUNERAL HOME FOR RICKETTS Ricketts Funeral Home		24b ADDRESS Myersville, MD 21773	
25a DATE REC'D BY REGISTRAR OCT 09 1987		25b REGISTRAR'S SIGNATURE John A. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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67936 OCT-3187

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8730650

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ANNA MARY LOUGHMAN			2a DATE OF DEATH MONTH DAY YEAR October 1, 1987		2b HOUR M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR August 10, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS	IF UNDER 1 YEAR IF UNDER 1 YEAR IF UNDER 1 YEAR
7a BIRTHPLACE (COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1620 Bennie Avenue		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland	13b COUNTY Washington	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 1620 Bennie Avenue 21740	
14 FATHER'S NAME FIRST MIDDLE LAST John Winghart		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Lutzenkertzer			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. - - - 176-36-7194	17 INFORMANT ADDRESS James P. Winghart Hagerstown, Maryland			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (1) (this hospital) attended the deceased from 19 to 19 that (1) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.					
22b SIGNATURE <u>Abdul Waheed MD</u>		DEGREE MD		22c DATE SIGNED 10/1/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Abdul Waheed MD		22e ADDRESS 1610 Oak Hill Avenue, Hagerstown, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-4-87	23c NAME OF CEMETERY OR CREMATORY West Union Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE West Union, Greene Penna.	
24 FUNERAL DIRECTOR NAME Andrew K. Coffman Funeral Home, Inc.		25a DATE REC'D. BY REGISTRAR OCT 07 1987		25b REGISTRAR'S SIGNATURE <u>Julia L. Anderson</u>	

MEDICAL CERTIFICATION

BP

DHMH 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30657

1 DECEASED NAME (TYPE OR PRINT) Dorothy Virginia Merriman				2a. DATE OF DEATH MONTH DAY YEAR Oct 11 1987				2b. HOUR 10 8 p.m.			
3 SEX Female		4 RACE CAUC		5 DATE OF BIRTH MONTH DAY YEAR Sept 27 1912				6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS			
7a BIRTHPLACE (COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON Co. MD			
10 CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON Co. Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK-Retired				12b KIND OF BUSINESS OR INDUSTRY ACME	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD. COUNTY FRED CITY OR TOWN BRUNSWICK				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE PEACH TREE DR. 21716					
14 FATHER'S NAME FIRST MIDDLE LAST William Harry LONG				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE FRANCES BROWN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 217-32-6875		17 INFORMANT MRS NANCY MERRIMAN				ADDRESS 300 Shenandoah Ave Charlottesville VA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) chronic obstructive pulmonary disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE G. W. Seal				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/12/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WATHEED MD				22e ADDRESS 1610- Oak Hill Ave. HAGERSTOWN MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b DATE 10-11-87		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (CITY OR TOWN) COUNTY STATE			
24 FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.				25a DATE REC'D BY REGISTRAR OCT 20 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

070391 NOV 28 1987		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		30652	
FOR STATE REGISTRAR		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Loretta Mae Miller		7a DATE OF DEATH MONTH DAY YEAR October 24, 1987		7b HOUR M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 14, 1914	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 AGE (IN YEARS LAST BIRTHDAY) 73 YRS MONTHS DAYS HOURS MIN	
10 CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 208 E. Potomac St.		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Production		12b KIND OF BUSINESS OR INDUSTRY Aircraft			
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Williamsport	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 208 E. Potomac St. 21795			
14 FATHER'S NAME FIRST MIDDLE LAST Simon Brewer Byers		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mray Virginia Hawbaker			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-8410		17 INFORMANT ADDRESS Shelva J. Buzzard (item 13 above)	
18 CAUSE OF DEATH (Enter only one cause per line, or for 1b, 1c, and 1d) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF Approximate interval between onset and death 4 months 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITIONS GIVEN IN PART 1 (a) Chronic Obstructive Pulmonary Disease					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		19c AUTOPT YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 - OR PART 2)	
21a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that on this hospital attended the deceased from 19/4/87 to 10/24/87 and that on my opinion death occurred on the date and hour and from the causes stated		22b SIGNATURE Robert Brull, MD		22c DATE SIGNED 10/26/87	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 27, 1987		23c NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
24 FUNERAL DIRECTOR NAME Major M. Osborne		24b ADDRESS Williamsport, MD 21795		25a DATE REC'D. BY REGISTRAR OCT 30 1987	
25b REGISTRAR'S SIGNATURE 1/2					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VADA M. MUMMERT			2a. DATE OF DEATH MONTH DAY YEAR 10 13 87		2b. HOUR 9:20 AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 22 34		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Food Processing	
13a. STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Greencastle		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 5300 Bino Rd. Greencastle, PA. 17225		14. FATHER'S NAME FIRST MIDDLE LAST David A. Gerhold		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva Hornbaker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	
16b. SOCIAL SECURITY NO 186-28-5821		17. INFORMANT Alvin E. Mummert		ADDRESS 5300 Bino Rd. Greencastle, PA. 17225			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pulmonary insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Metastatic breast carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs. yrs.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 10/13 19 87 to 10/13 19 87 that (we) I saw the deceased alive on 10/13 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) I did (did not) view the body after death.							
22b. SIGNATURE Charles R. Chaney M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles R. Chaney M.D.		22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md. 21740					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-17-1987		23c. NAME OF CEMETERY OR CREMATORY Macedonia Church Cemetery		23d. LOCATION (CITY OR TOWN) Antrim Twp. Franklin Co. PA	
24. FUNERAL DIRECTOR NAME Robert C. May		ADDRESS 112 E. Baltimore Street Greencastle, PA 17225		25a. DATE REC'D. BY REGISTRAR OCT 22 1987		25b. REGISTRAR'S SIGNATURE Davidson-Rodell	

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 CHICAGO, ILL. 60607

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1- CEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
SHIRLEY EVELYN NEILL			OCTOBER 15, 1987			10:49 PM				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE		7. IF UNDER 1 YEAR		
FEMALE		WHITE		JUNE 9 1935		52		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		U.S.A.				WASHINGTON COUNTY MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN		520 N. MULBERRY STREET				CLERK		RETAIL		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
MARYLAND			WASHINGTON		HAGERSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE				
CLARANCE			MARTIN			520 N. MULBERRY STREET 21740				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No					GEORGE T. NEILL SAME AS 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Edisonia Laryx</i>								1984		
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
<i>Alcoholism, Malnutrition</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>June 9</i> , 19 <i>87</i> , to <i>June 9</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>June 9</i> , 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Gloria F. Pura</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLORIA F. PURA			22e. ADDRESS 366 Hill St Hagerstown							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL			10-20-87		ROCKY GAP VETS. CEM.		CUMBERLAND WASH. MD.			
24 FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
GERALD N. MINNICH			305 N. POTYOMAC STREET HAGERSTOWN, MARYLAND			OCT 26 1987				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then the funeral director should file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, death or traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (PRINT) HARRY N. NEWTON		2a. DATE OF DEATH MONTH DAY YEAR 10/15/87 10 15 87		2b. HOUR:MIN:SEC 2:30 A.M.	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR November 01, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 74 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired heavy Equip. Operator		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) Walter Ray Newton		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Katie Pauline Exline		16. STREET ADDRESS / ZIP CODE 824 E. Patrick Street 21701	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-10-1764		17. INFORMANT Joann Lee	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiomyopathy, Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Hyperandrogen Diabetes Coma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>per min</u> <u>1 day</u> <u>2 w</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Potential Sepsis, Potential CVA, Potential Ar MI, ASCVD, Dementia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7. 29</u> 19 <u>87</u> to <u>10. 15</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10. 14</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>VASANT DATTA, MD</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>10-15-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASANT DATTA, MD		22e. ADDRESS 334 MILL ST, HAGERSTOWN, MD 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/17/87	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Maryland
24. FUNERAL DIRECTOR <u>R. E. Dailey & Son, P.A.</u>		1201 N. Market St. Frederick, Md.		25a. DATE REC'D BY REGISTRAR OCT 22 1987	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1- STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
Martha Macie Noll		female		white	
5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
November 13, 1900		86 YRS		Pennsylvania	
7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
U.S.A.				WASHINGTON COUNTY MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BOONESTOWN		FARMER KEEDY MEMORIAL HOME		housewife	
13a STATE		13b COUNTY		13c CITY OR TOWN	
Pennsylvania		Centre		Bellefonte	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Charles P. Reese		Minnie Eckley			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
no		195-16-8062		Mr. Gilbert C. Noll, Hagerstown, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1 DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) cardiac arrest					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) acute pneumonia					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
				P.M. 19	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		22c DATE SIGNED	
		ABDUL WATHERED, MD		10/30/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
ABDUL WATHERED, MD		1610 - Oak Hill Ave. Hagerstown, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
burial		Nov. 2, 1987		Centre County Park	
23d LOCATION CITY OR TOWN COUNTY STATE		23e NAME OF CEMETERY OR CREMATORY		23f LOCATION CITY OR TOWN COUNTY STATE	
State College, Centre, PA.		State College, Centre, PA.		State College, Centre, PA.	
24 FUNERAL DIRECTOR NAME ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland		NOV 04 1987		Julia Davidson-Randall	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Anthony J. NUSBAUM			2a DATE OF DEATH MONTH DAY YEAR Oct. 18, 1987			2b HOUR 8 45 A.M.			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1932		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 55		7 IF UNDER 1 YEAR IF UNDER 12 HRS IF UNDER 24 HRS IF UNDER 48 HRS IF UNDER 72 HRS IF UNDER 96 HRS IF UNDER 120 HRS IF UNDER 144 HRS IF UNDER 168 HRS IF UNDER 192 HRS IF UNDER 216 HRS IF UNDER 240 HRS IF UNDER 264 HRS IF UNDER 288 HRS IF UNDER 312 HRS IF UNDER 336 HRS IF UNDER 360 HRS IF UNDER 384 HRS IF UNDER 408 HRS IF UNDER 432 HRS IF UNDER 456 HRS IF UNDER 480 HRS IF UNDER 504 HRS IF UNDER 528 HRS IF UNDER 552 HRS IF UNDER 576 HRS IF UNDER 600 HRS IF UNDER 624 HRS IF UNDER 648 HRS IF UNDER 672 HRS IF UNDER 696 HRS IF UNDER 720 HRS IF UNDER 744 HRS IF UNDER 768 HRS IF UNDER 792 HRS IF UNDER 816 HRS IF UNDER 840 HRS IF UNDER 864 HRS IF UNDER 888 HRS IF UNDER 912 HRS IF UNDER 936 HRS IF UNDER 960 HRS IF UNDER 984 HRS IF UNDER 1008 HRS IF UNDER 1032 HRS IF UNDER 1056 HRS IF UNDER 1080 HRS IF UNDER 1104 HRS IF UNDER 1128 HRS IF UNDER 1152 HRS IF UNDER 1176 HRS IF UNDER 1200 HRS IF UNDER 1224 HRS IF UNDER 1248 HRS IF UNDER 1272 HRS IF UNDER 1296 HRS IF UNDER 1320 HRS IF UNDER 1344 HRS IF UNDER 1368 HRS IF UNDER 1392 HRS IF UNDER 1416 HRS IF UNDER 1440 HRS IF UNDER 1464 HRS IF UNDER 1488 HRS IF UNDER 1512 HRS IF UNDER 1536 HRS IF UNDER 1560 HRS IF UNDER 1584 HRS IF UNDER 1608 HRS IF UNDER 1632 HRS IF UNDER 1656 HRS IF UNDER 1680 HRS IF UNDER 1704 HRS IF UNDER 1728 HRS IF UNDER 1752 HRS IF UNDER 1776 HRS IF UNDER 1800 HRS IF UNDER 1824 HRS IF UNDER 1848 HRS IF UNDER 1872 HRS IF UNDER 1896 HRS IF UNDER 1920 HRS IF UNDER 1944 HRS IF UNDER 1968 HRS IF UNDER 1992 HRS IF UNDER 2016 HRS IF UNDER 2040 HRS IF UNDER 2064 HRS IF UNDER 2088 HRS IF UNDER 2112 HRS IF UNDER 2136 HRS IF UNDER 2160 HRS IF UNDER 2184 HRS IF UNDER 2208 HRS IF UNDER 2232 HRS IF UNDER 2256 HRS IF UNDER 2280 HRS IF UNDER 2304 HRS IF UNDER 2328 HRS IF UNDER 2352 HRS IF UNDER 2376 HRS IF UNDER 2400 HRS IF UNDER 2424 HRS IF UNDER 2448 HRS IF UNDER 2472 HRS IF UNDER 2496 HRS IF UNDER 2520 HRS IF UNDER 2544 HRS IF UNDER 2568 HRS IF UNDER 2592 HRS IF UNDER 2616 HRS IF UNDER 2640 HRS IF UNDER 2664 HRS IF UNDER 2688 HRS IF UNDER 2712 HRS IF UNDER 2736 HRS IF UNDER 2760 HRS IF UNDER 2784 HRS IF UNDER 2808 HRS IF UNDER 2832 HRS IF UNDER 2856 HRS IF UNDER 2880 HRS IF UNDER 2904 HRS IF UNDER 2928 HRS IF UNDER 2952 HRS IF UNDER 2976 HRS IF UNDER 3000 HRS IF UNDER 3024 HRS IF UNDER 3048 HRS IF UNDER 3072 HRS IF UNDER 3096 HRS IF UNDER 3120 HRS IF UNDER 3144 HRS IF UNDER 3168 HRS IF UNDER 3192 HRS IF UNDER 3216 HRS IF UNDER 3240 HRS IF UNDER 3264 HRS IF UNDER 3288 HRS IF UNDER 3312 HRS IF UNDER 3336 HRS IF UNDER 3360 HRS IF UNDER 3384 HRS IF UNDER 3408 HRS IF UNDER 3432 HRS IF UNDER 3456 HRS IF UNDER 3480 HRS IF UNDER 3504 HRS IF UNDER 3528 HRS IF UNDER 3552 HRS IF UNDER 3576 HRS IF UNDER 3600 HRS IF UNDER 3624 HRS IF UNDER 3648 HRS IF UNDER 3672 HRS IF UNDER 3696 HRS IF UNDER 3720 HRS IF UNDER 3744 HRS IF UNDER 3768 HRS IF UNDER 3792 HRS IF UNDER 3816 HRS IF UNDER 3840 HRS IF UNDER 3864 HRS IF UNDER 3888 HRS IF UNDER 3912 HRS IF UNDER 3936 HRS IF UNDER 3960 HRS IF UNDER 3984 HRS IF UNDER 4008 HRS IF UNDER 4032 HRS IF UNDER 4056 HRS IF UNDER 4080 HRS IF UNDER 4104 HRS IF UNDER 4128 HRS IF UNDER 4152 HRS IF UNDER 4176 HRS IF UNDER 4200 HRS IF UNDER 4224 HRS IF UNDER 4248 HRS IF UNDER 4272 HRS IF UNDER 4296 HRS IF UNDER 4320 HRS IF UNDER 4344 HRS IF UNDER 4368 HRS IF UNDER 4392 HRS IF UNDER 4416 HRS IF UNDER 4440 HRS IF UNDER 4464 HRS IF UNDER 4488 HRS IF UNDER 4512 HRS IF UNDER 4536 HRS IF UNDER 4560 HRS IF UNDER 4584 HRS IF UNDER 4608 HRS IF UNDER 4632 HRS IF UNDER 4656 HRS IF UNDER 4680 HRS IF UNDER 4704 HRS IF UNDER 4728 HRS IF UNDER 4752 HRS IF UNDER 4776 HRS IF UNDER 4800 HRS IF UNDER 4824 HRS IF UNDER 4848 HRS IF UNDER 4872 HRS IF UNDER 4896 HRS IF UNDER 4920 HRS IF UNDER 4944 HRS IF UNDER 4968 HRS IF UNDER 4992 HRS IF UNDER 5016 HRS IF UNDER 5040 HRS IF UNDER 5064 HRS IF UNDER 5088 HRS IF UNDER 5112 HRS IF UNDER 5136 HRS IF UNDER 5160 HRS IF UNDER 5184 HRS IF UNDER 5208 HRS IF UNDER 5232 HRS IF UNDER 5256 HRS IF UNDER 5280 HRS IF UNDER 5304 HRS IF UNDER 5328 HRS IF UNDER 5352 HRS IF UNDER 5376 HRS IF UNDER 5400 HRS IF UNDER 5424 HRS IF UNDER 5448 HRS IF UNDER 5472 HRS IF UNDER 5496 HRS IF UNDER 5520 HRS IF UNDER 5544 HRS IF UNDER 5568 HRS IF UNDER 5592 HRS IF UNDER 5616 HRS IF UNDER 5640 HRS IF UNDER 5664 HRS IF UNDER 5688 HRS IF UNDER 5712 HRS IF UNDER 5736 HRS IF UNDER 5760 HRS IF UNDER 5784 HRS IF UNDER 5808 HRS IF UNDER 5832 HRS IF UNDER 5856 HRS IF UNDER 5880 HRS IF UNDER 5904 HRS IF UNDER 5928 HRS IF UNDER 5952 HRS IF UNDER 5976 HRS IF UNDER 6000 HRS IF UNDER 6024 HRS IF UNDER 6048 HRS IF UNDER 6072 HRS IF UNDER 6096 HRS IF UNDER 6120 HRS IF UNDER 6144 HRS IF UNDER 6168 HRS IF UNDER 6192 HRS IF UNDER 6216 HRS IF UNDER 6240 HRS IF UNDER 6264 HRS IF UNDER 6288 HRS IF UNDER 6312 HRS IF UNDER 6336 HRS IF UNDER 6360 HRS IF UNDER 6384 HRS IF UNDER 6408 HRS IF UNDER 6432 HRS IF UNDER 6456 HRS IF UNDER 6480 HRS IF UNDER 6504 HRS IF UNDER 6528 HRS IF UNDER 6552 HRS IF UNDER 6576 HRS IF UNDER 6600 HRS IF UNDER 6624 HRS IF UNDER 6648 HRS IF UNDER 6672 HRS IF UNDER 6696 HRS IF UNDER 6720 HRS IF UNDER 6744 HRS IF UNDER 6768 HRS IF UNDER 6792 HRS IF UNDER 6816 HRS IF UNDER 6840 HRS IF UNDER 6864 HRS IF UNDER 6888 HRS IF UNDER 6912 HRS IF UNDER 6936 HRS IF UNDER 6960 HRS IF UNDER 6984 HRS IF UNDER 7008 HRS IF UNDER 7032 HRS IF UNDER 7056 HRS IF UNDER 7080 HRS IF UNDER 7104 HRS IF UNDER 7128 HRS IF UNDER 7152 HRS IF UNDER 7176 HRS IF UNDER 7200 HRS IF UNDER 7224 HRS IF UNDER 7248 HRS IF UNDER 7272 HRS IF UNDER 7296 HRS IF UNDER 7320 HRS IF UNDER 7344 HRS IF UNDER 7368 HRS IF UNDER 7392 HRS IF UNDER 7416 HRS IF UNDER 7440 HRS IF UNDER 7464 HRS IF UNDER 7488 HRS IF UNDER 7512 HRS IF UNDER 7536 HRS IF UNDER 7560 HRS IF UNDER 7584 HRS IF UNDER 7608 HRS IF UNDER 7632 HRS IF UNDER 7656 HRS IF UNDER 7680 HRS IF UNDER 7704 HRS IF UNDER 7728 HRS IF UNDER 7752 HRS IF UNDER 7776 HRS IF UNDER 7800 HRS IF UNDER 7824 HRS IF UNDER 7848 HRS IF UNDER 7872 HRS IF UNDER 7896 HRS IF UNDER 7920 HRS IF UNDER 7944 HRS IF UNDER 7968 HRS IF UNDER 7992 HRS IF UNDER 8016 HRS IF UNDER 8040 HRS IF UNDER 8064 HRS IF UNDER 8088 HRS IF UNDER 8112 HRS IF UNDER 8136 HRS IF UNDER 8160 HRS IF UNDER 8184 HRS IF UNDER 8208 HRS IF UNDER 8232 HRS IF UNDER 8256 HRS IF UNDER 8280 HRS IF UNDER 8304 HRS IF UNDER 8328 HRS IF UNDER 8352 HRS IF UNDER 8376 HRS IF UNDER 8400 HRS IF UNDER 8424 HRS IF UNDER 8448 HRS IF UNDER 8472 HRS IF UNDER 8496 HRS IF UNDER 8520 HRS IF UNDER 8544 HRS IF UNDER 8568 HRS IF UNDER 8592 HRS IF UNDER 8616 HRS IF UNDER 8640 HRS IF UNDER 8664 HRS IF UNDER 8688 HRS IF UNDER 8712 HRS IF UNDER 8736 HRS IF UNDER 8760 HRS IF UNDER 8784 HRS IF UNDER 8808 HRS IF UNDER 8832 HRS IF UNDER 8856 HRS IF UNDER 8880 HRS IF UNDER 8904 HRS IF UNDER 8928 HRS IF UNDER 8952 HRS IF UNDER 8976 HRS IF UNDER 9000 HRS IF UNDER 9024 HRS IF UNDER 9048 HRS IF UNDER 9072 HRS IF UNDER 9096 HRS IF UNDER 9120 HRS IF UNDER 9144 HRS IF UNDER 9168 HRS IF UNDER 9192 HRS IF UNDER 9216 HRS IF UNDER 9240 HRS IF UNDER 9264 HRS IF UNDER 9288 HRS IF UNDER 9312 HRS IF UNDER 9336 HRS IF UNDER 9360 HRS IF UNDER 9384 HRS IF UNDER 9408 HRS IF UNDER 9432 HRS IF UNDER 9456 HRS IF UNDER 9480 HRS IF UNDER 9504 HRS IF UNDER 9528 HRS IF UNDER 9552 HRS IF UNDER 9576 HRS IF UNDER 9600 HRS IF UNDER 9624 HRS IF UNDER 9648 HRS IF UNDER 9672 HRS IF UNDER 9696 HRS IF UNDER 9720 HRS IF UNDER 9744 HRS IF UNDER 9768 HRS IF UNDER 9792 HRS IF UNDER 9816 HRS IF UNDER 9840 HRS IF UNDER 9864 HRS IF UNDER 9888 HRS IF UNDER 9912 HRS IF UNDER 9936 HRS IF UNDER 9960 HRS IF UNDER 9984 HRS IF UNDER 10000 HRS	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) Adenocarcinoma of lung

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (Enter nature of injury in item 1b, Part 2, or Part 7)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (the hospital) attended the deceased from 10-17 19 87 to 10-18 19 87 that (I) (we) last
saw the deceased alive on 10-17 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING MEDICAL STAFF
PHYSICIAN ☒ DIRECTOR ☐ PHYSICIAN ☐

22c DATE SIGNED

10-18-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Eric M. ?

M.D.

22e ADDRESS

Hagerstown, Md. 21740

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b DATE

10-21-1987

23c NAME OF CEMETERY OR CREMATORY

Blue Ridge Cemetery Thurmont, Frederick, Md

23d LOCATION
(CITY OR TOWN)

COUNTY

STATE

24 FUNERAL HOME

R.E. DAILEY & SON, PA
615 E. Main Street
Thurmont, Md. 21788

25a DATE REC'D BY REGISTRAR

NOV 06 1987

25b REGISTRAR'S SIGNATURE

[Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

100-451-32015

068970 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jane Barrett O'Keefe			2a DATE OF DEATH MONTH DAY YEAR October 13, 1987		2b HOUR 3PM					
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR October 14, 1917		6 AGE (IN YEARS LAST BIRTHDAY) YRS 69		7b HOUR MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington		MD		
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 955 Greenbriar Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) - - -		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 955 Greenbriar Road 21740	
14 FATHER'S NAME FIRST MIDDLE LAST George A. Phillips			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Barrett							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b SOCIAL SECURITY NO. 053-16-9328D		17 INFORMANT ADDRESS Thomas S. O'Keefe, Jr.					
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs approx.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bronchopneumonia										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22 I certify that (I) (this hospital) attended the deceased from 9/15, 1985 to 10/12, 1987 that (I) (we) last saw the deceased alive on 10/12/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)										
27b SIGNATURE R. Campbell						DEGREE M.D.		27c DATE SIGNED 10/19/87		
27d PHYSICIAN'S NAME (TYPE OR PRINT) R. Campbell						27e ADDRESS Hagerstown Md				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b DATE Oct. 16, 1987		23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a DATE REC'D. BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE Lia Davidson-Randall		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR <i>Charles R. Orendorff</i>									
1a DECEASED NAME (TYPE OR PRINT) <i>Charles R. Orendorff</i>				2a DATE OF DEATH MONTH DAY YEAR <i>10 29 87</i>		2b HOUR <i>144</i> P.M.			
3 SEX <i>M</i>		4 RACE <i>W</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>11 05 06</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>US</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Washington County MD</i>			
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>Maryland</i>		13b COUNTY <i>Wash.</i>		13c CITY OR TOWN <i>Hagerstown</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>117 Clearview Rd 21740</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Charles Orendorff</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lottie Hamm</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>yes</i>					
16b SOCIAL SECURITY NO. <i>W.W. II 188 03 3898</i>		17 INFORMANT ADDRESS <i>Mrs. Sally C. Orendorff, Hagerstown, MD.</i>							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO OR AS A CONSEQUENCE OF <i>Arteriosclerotic Heart Disease</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) <i>Arteriosclerotic Heart Disease</i> DUE TO OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Gastro intestinal hemorrhage</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACILITY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>11/6/53</i> 19 to <i>10/29/87</i> 19 that (I) (we) last saw the deceased alive on <i>10/29/87</i> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b SIGNATURE <i>Robert H. Campbell</i>				DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>10/31/87</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. CAMPBELL</i>				22e ADDRESS <i>HAGERSTOWN MD.</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b DATE <i>Nov. 2, 1987</i>		23c NAME OF CEMETERY OR CREMATORY <i>Harmony Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Falling Waters, West Virginia</i>			
24 FUNERAL DIRECTOR NAME ADDRESS <i>MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, MD. 21740</i>				25a DATE REC'D. BY REGISTRAR <i>NOV 04 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

70144 OCT 29 1987

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Amos E. Palmer			2a DATE OF DEATH MONTH DAY YEAR Oct 26 1987		2b HOUR 2:53 A M
3 SEX Male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR dec 26 1930		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 56	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Veterinarian		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY Frederick	13c CITY OR TOWN Middletown	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Malcolm S. Palmer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rensburg			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-28-8941		17 INFORMANT ADDRESS 1639 Monument Rd. Middletown Md. 21769	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Epithelioid Leiomyosarcoma of the pelvis DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Mar 1987 Mar 1987
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION Mar 30 1987	19b CONDITION FOR WHICH OPERATION WAS PERFORMED Epithelioid leiomyosarcoma	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19 none	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR none	21c HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 3	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none	21f LOCATION STREET CITY OR TOWN COUNTY STATE none	
22a I certify that (I) (this hospital) attended the deceased from March 19 87 to Oct 24 1987 that (I) (we) last saw the deceased alive on Oct 24 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.			
22b SIGNATURE Francisco G. Japzon		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED Oct 26 1987
22d PHYSICIAN'S NAME (TYPE OR PRINT) Francisco G. Japzon, M.D.		22e ADDRESS 346 Mill St. Hagerstown, Md 21740	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-28-87	23c NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Boonsboro Washington Maryland
24 FUNERAL DIRECTOR NAME ADDRESS John H. Bast Jr. Boonsboro Maryland 21713		25a DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE Oct 28 1987	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred Jane PATRICK			2a. DATE OF DEATH MONTH DAY YEAR October 22, 1987		2b. HOUR 4:05pm
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3 6 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD	
10. CITY OR TOWN OF DEATH WILLIAMSPORT	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOMWOOD NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND			13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN FERRELL PATRICK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE BREWER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 251-14-0904	17. INFORMANT ADDRESS PHYLLIS HENRY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respirator failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastatic breast carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> 19 <u>87</u> to <u>10/22</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we last saw the deceased on <u>10/13</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we last saw the body after death).					
22b. SIGNATURE <u>Alan W. Ditt</u>		DEGREE MD		22c. DATE SIGNED 10/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan W. Ditt M.D.		22e. ADDRESS 1610 Oak Hill Ave Hyattsville 21740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 10-24-87	23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SMITHSBURG WASH. MD
24. FUNERAL DIRECTOR NAME GERALD N. MINNICH		305 N. POTOMAC ST. HAG., MD.		25a. DATE REC'D BY REGISTRAR 10/30/87 25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove certificate from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a summary of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a summary of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

16. The sixteenth part is a summary of the work done during the year.

17. The seventeenth part is a summary of the work done during the year.

18. The eighteenth part is a summary of the work done during the year.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR ANTONIO (NMN) PENNESI					REG. NO.				
DECEASED NAME (TYPE OR PRINT) Antonio NMN Pennesi					2a DATE OF DEATH October 21, 1987			2b HOUR 4 ⁵⁵ A.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH March 1, 1896		6 AGE (IN YEARS, LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b KIND OF BUSINESS OR INDUSTRY Restaurant	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 14 East Washington Street 21740	
14 FATHER'S NAME FIRST MIDDLE LAST Jossippi Pennesi				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Splendora (Unknown)					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - -		17 INFORMANT Giovanna Pennesi		ADDRESS 14 East Washington Street Hagerstown, Maryland			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>acute congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>hrs</u> <u>hrs</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>left sided hemiplegia diabetes m.</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>Aug</u> 19 <u>80</u> to <u>Oct 21</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10-21</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Harold R. Titch Jr MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10-22-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. Titch MD</u>				22e ADDRESS <u>345 Mill St Hagerstown, Md</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-24-87		23c NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Pk.		23d LOCATION (CITY OR TOWN COUNTY STATE) Hagerstown, Washington, Md.			
24 FUNERAL DIRECTOR NAME Andrew K. Coffman Funeral Home, Inc.				Hagerstown, Md.		25a DATE REC'D. BY REGISTRAR OCT 27 1987		25b REGISTRAR'S SIGNATURE	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1. DECEASED NAME (TYPE OR PRINT) James Roderick Price			2a. DATE OF DEATH MONTH DAY YEAR 10 24 87			2b. HOUR 3 p.m.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 07 08 08		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD	
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Reeders Memorial Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Project Engr.	
12b. KIND OF BUSINESS OR INDUSTRY Manufacturing							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Sharpsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Limkiln Rd. 21782							
14. FATHER'S NAME FIRST MIDDLE LAST Norman Wellington Price				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Maude Foster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 072-07-3233		17. INFORMANT ADDRESS Sue A. Jabin Grand Rapids, Mich.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>AS CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22. I certify that (I) [this hospital] attended the deceased from <u>10-23-87</u> 19 <u>87</u> to <u>10-24</u> 19 <u>87</u> that (I) [we] lost saw the deceased alive on <u>10-23-87</u> 19 <u>87</u> and that in (my) [our] opinion death occurred on the date and hour and from the causes stated above. (I) [we] did (I) did not view the body after death							
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10-25-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VASANT DATTA</u>		22e. ADDRESS <u>334 MILL ST. HAGERSTOWN, MD 21746</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 25, 87		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Major M. Osborne Williamsport, MD 21795				25a. DATE REC'D BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

070005-10-501



OCT 20 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use in the burial transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked on item 18, show any injury or other traumatic event, the medical examiner will be notified in person.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR										30664	
2 DECEASED NAME (TYPE OR PRINT) Mary Frances Renner										2a DATE OF DEATH MONTH DAY YEAR 10 9 87 3:45a M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 05 20 10		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7b HOUR			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD					
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H/W		12b KIND OF BUSINESS OR INDUSTRY					
13a STATE MD		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1021 Murdock Avenue 21740			
14 FATHER'S NAME FIRST MIDDLE LAST Harry A. Palmer				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth A. Mills							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 216-07-1232		17 INFORMANT ADDRESS							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY Acute Renal Failure IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Osteoarthritis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-18 19 87 to 10-9 19 87 that I <input checked="" type="checkbox"/> last saw the deceased alive on 19 and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (b) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> view the body after death.											
22b SIGNATURE <i>Kyung Kim</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 10-9-87			
22e PHYSICIAN'S NAME (TYPE OR PRINT) Kyung KIM, M.D.				22f ADDRESS 1500 Pennsylvania Avenue, Hagerstown, MD 21740							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b DATE October 19 1987		23c NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington Md.					
24 FUNERAL DIRECTOR NAME Minnich Funeral Home				ADDRESS 415 East Wilson Blvd Hagerstown, Md. 21740		25 DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE OCT 16 1987 <i>Julia Denson-Rodgers</i>					

BP

086351 OCT 1961

NON COTTON 2/08



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST Iva		MIDDLE Mae		LAST REVELL		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> Oct. 11 19 87		2b. HOUR 2:32 <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1914		6 AGE (IN YEARS) LAST BIRTHDAY YRS. 73		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2318 Dixie Drive		21740	
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Calvin Murray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Katherine Shoemaker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT B. Howard Revell, Hagerstown, Md.		ADDRESS 739-7062					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) #428 - CARDIAC FAILURE WITH ACUTE PULMONARY DUE TO, OR AS A CONSEQUENCE OF EDEMA Conditions, if any, which gave rise to immediate cause (a) stating the under-lying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 HOURS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS - UNCONTROLLED											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) DEPUTY		MEDICAL EXAMINER 217 WEST WASHINGTON STREET		DATE SIGNED Oct. 13, 1987					
ACTUAL SIGNATURE <i>Edward W. Ditto, III</i>		M.D. EDWARD W. DITTO, III, M.D.		ADDRESS HAGERSTOWN, MARYLAND 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Oct. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Parkhead Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Big Pool, Wash., Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25. DATE RECD. BY REGISTRAR OCT 16 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENALTY ITEM 1B, GIVE PARAGRAPHS 2, AND 3 TO THE FUNERAL DIRECTOR TO EXECUTE. PARAGRAPH 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, WITHIN 72 HOURS. RETURN PARAGRAPH 3 TO THE FUNERAL DIRECTOR. PARAGRAPH 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PIESON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
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(VR A15 ME (5))
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069594

OCT 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR

2a DECEASED NAME (TYPE OR PRINT) DANIEL B. RIDENOUR			2b DATE OF DEATH MONTH DAY YEAR 10/11/87			2c HOUR 12 05 AM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR FEB. 23, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8a BIRTHPLACE (COUNTRY) MARYLAND		8b CITIZEN OF WHAT COUNTRY? U.S.A.		8c MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MARYLAND		13c COUNTY FREDERICK		13d CITY OR TOWN THURMONT		13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f STREET ADDRESS / ZIP CODE BLUE MT. ROAD/21788	
14 FATHER'S NAME FIRST MIDDLE LAST EDWARD CHARLES RIDENOUR		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA NMI WETZEL		ADDRESS 699 PROSPECT AVE. DANIEL P. RIDENOUR WEST ORANGE, N.J. 07052					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT ADDRESS 699 PROSPECT AVE. DANIEL P. RIDENOUR WEST ORANGE, N.J. 07052					

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last <u>Severe Chronic obstructive Pulmonary Disease years</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Congestive Heart Failure

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b, PART 1 OR PART 2)			
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 1</u> 19 <u>87</u> to <u>October 11</u> 19 <u>87</u> that (I <input checked="" type="checkbox"/> have) last saw the deceased alive on <u>October 10</u> 19 <u>87</u> and that in (my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> did) <input checked="" type="checkbox"/> did not view the body after death.							
22b SIGNATURE <u>Fe U. Porciuncula M.D.</u>				DEGREE M.D.		22c DATE SIGNED 10/11/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>FE U. PORCIUNCULA</u>				22e ADDRESS <u>1500 PENNSYLVANIA AVE. HAGERSTOWN MD</u>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10/14/87		23c NAME OF CEMETERY OR CREMATORY BLUE RIDGE CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE THURMONT FREDRICK MARYLAND	
24 FUNERAL DIRECTOR NAME ROBERT E. DAILEY & SON, P.A. THURMONT, MD. 21788				25a DATE REC'D BY REGISTRAR OCT 22 1987		25b REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, single 3 should be detached for use on the burial transit permit. Two permits remove certificates. Pages 1 and 2 will be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Important: If item 21 is marked as item 18, give date, injury, and other significant event. The medical examiner will be notified.

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2025 OCT 10 AM 10:00

WILKINSON

WILKINSON



OCT 23 1961

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30567

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Argie Prosper Rinehart</i>			2a DATE OF DEATH MONTH DAY YEAR <i>Oct. 23, 1987</i>		2b HOUR <i>8:05 AM</i>		
3 SEX <i>female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>June 29, 1918</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD	
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <i>Maryland</i>		13b COUNTY <i>Washington</i>		13c CITY OR TOWN <i>Hagerstown</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET ADDRESS <i>1745 Edgewood Hill Circle</i>		13f CITY OR TOWN <i>21740</i>		13g STATE <i>MD</i>		13h ZIP CODE	
14 FATHER'S NAME FIRST MIDDLE LAST <i>John Prosper</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances Novella</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>214-09-3633</i>	
16c ADDRESS <i>William N. Rinehart, Hagerstown, Md.</i>		17 INFORMANT <i>William N. Rinehart, Hagerstown, Md.</i>		18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma to liver</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>probable carcinoma of pancreas</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 wks</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Arteriosclerotic cardiovascular disease</i>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		21g DATE OF OPERATION		21h CONDITION FOR WHICH OPERATION WAS PERFORMED	
22 I certify that (a) (this hospital) attended the deceased from <i>April</i> 19 <i>79</i> to <i>Oct 23</i> 19 <i>87</i> , that (b) (we) saw the deceased alive on <i>Oct 22</i> 19 <i>87</i> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did not) view the body after death.							
22b SIGNATURE <i>Richard E. Smith, MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard E. Smith, MD</i>		22e ADDRESS <i>1708 Oak Hill Ave. Hagerstown, Md.</i>		23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b DATE <i>Oct. 26, 1987</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>		24 FUNERAL DIRECTOR NAME <i>MINNICH FUNERAL HOME</i>		25a DATE REC'D. BY REGISTRAR <i>OCT 28 1987</i>	
24b ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c REGISTRAR'S NAME <i>[Name]</i>		25d REGISTRAR'S TITLE <i>[Title]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

050107 OCT 28 81

10/28/81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) EDITH E. ROW			2a. DATE OF DEATH MONTH 10 DAY 22 YEAR 87			2b. HOUR 8:50 PM		
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH May DAY 19 YEAR 1900		6 AGE (IN YEARS LAST BIRTHDAY) 87		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Newport South Wales, England		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD		
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 11 W. Baltimore St., Apt. 628 21740
14 FATHER'S NAME FIRST Windsor MIDDLE Gibbon LAST Gibbon		15. MOTHER'S MAIDEN NAME FIRST Jane MIDDLE Chandler LAST Chandler						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 219 05 6468		17 INFORMANT Edith E. Row (pre-arrangements)				
18 CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET 		CITY OR TOWN 		STATE
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/17 19 87 to 10/22 19 87 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on above, (b) <input checked="" type="checkbox"/> did not view the body after death and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated								
22b SIGNATURE Rose Marie Chan M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 10/22/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROSE MARIE CHAN, M.D.				22e ADDRESS Western Maryland Center, Hagerstown				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Oct. 26, 1987		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION (CITY OR TOWN) Hagerstown, Wash., Maryland		
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a DATE REC'D. BY REGISTRAR OCT 28 1987		25b REGISTRAR'S SIGNATURE		

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C. 20250

50174 E. K.W. 10/17/52

Perennial plant habit
Climbing or trailing habit

After 2 1/2 years after
the first year in the
first year in the first year

069086

OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nelson S. Russ			2a. DATE OF DEATH MONTH DAY YEAR 10-13-87			2b. HOUR 7:55 A.M.			
3. SEX Male		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 02 07 1929		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 DAY HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY MD. HEALTH DPT.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 675 PENNSYLVANIA AVENUE 21740	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM MCKINLEY RUSS SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA WILLIAMS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NAVY		17. INFORMANT CATHERINE RUSS		ADDRESS SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Intufficiency / Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic CA to contralateral lumen cervical nodes and other soft tissue of neck</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Larynx</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Acute M.I. (10-4-87) 2° to Hypertensive-Andtherosclerotic C-V Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>2 June 1985</u> to <u>13 Oct 1987</u> , that (1) (we) last saw the deceased alive on <u>12 Oct 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.									
22b. SIGNATURE <u>W. N. Fender</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 13 Oct 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. Fender				22e. ADDRESS 138 E. Antietam St, Hagerstown MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-17-87		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH MD.			
24. FUNERAL DIRECTOR NAME GERALD N. MINNICH				305 N. POTOMAC STREET HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR OCT 19 1987		25b. REGISTRAR'S SIGNATURE Julia D. ...	

MEDICAL CERTIFICATION

99

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and calculations, including a table with columns labeled 'X', 'Y', 'Z', 'W', 'V', 'U', 'T', 'S', 'R', 'Q', 'P', 'O', 'N', 'M', 'L', 'K', 'J', 'I', 'H', 'G', 'F', 'E', 'D', 'C', 'B', 'A'. The text is written in cursive and includes various mathematical expressions and data points.

12

069558 OCT 23 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of page 1.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

2a BASED NAME
(TYPE OR PRINT)

FIRST *Connie Faith* MIDDLE *F* LAST *Semler*

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
10 17 87 *9:30 A*

3 SEX
female

4 RACE
white

5 DATE OF BIRTH
MONTH DAY YEAR
Sept. 20, 1942

6 AGE (IN YEARS LAST BIRTHDAY)
45

IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b CITIZEN OF WHAT COUNTRY?
USA

8 MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH
Washington MD

10 CITY OR TOWN OF DEATH
Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington County Hospital

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
clerk

12b KIND OF BUSINESS OR INDUSTRY
food

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE
Maryland

13b COUNTY
Washington

13c CITY OR TOWN
Hagerstown

13d INSIDE CITY LIMITS?
YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE
Route 3, Box 168S 21740

14 FATHER'S NAME
FIRST *Charles* MIDDLE *F.* LAST *Schelle*

15 MOTHER'S MAIDEN NAME
FIRST *Marie* MIDDLE *Faith* LAST *Semler*

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN) *no*

16b SOCIAL SECURITY NO
220-40-0103

17 INFORMANT ADDRESS
Donald Semler, Hagerstown, Md. 21740

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) *Pneumonia*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) *Hodgkins Disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 weeks

4 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. *19*

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)

21f LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from *10/17/87* to *10/18/87* that (I) (we) last saw the deceased alive on *10/17/87* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒

MEDICAL DIRECTOR ☐

STAFF PHYSICIAN ☐

22c DATE SIGNED

22d PHYSICIAN'S NAME (TYPE OR PRINT)

22e ADDRESS

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial

23b DATE
Oct. 20, 1987

23c NAME OF CEMETERY OR CREMATORY
Green Lawn Mem. Park

23d LOCATION
(CITY OR TOWN) COUNTY STATE
Williamsport, Wash., Maryland

24 FUNERAL DIRECTOR
*MINNICH FUNERAL HOME
Hagerstown, Md. 21740*

415 E. Wilson Blvd

DATE REC'D BY REGISTRAR IN REGISTRAR'S SIGNATURE
OCT 22 1987

100-139 927 930

10-10-11

10-10-11

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068751 OCT 6 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30671

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Barbara Grace Sierver</u>			2a DATE OF DEATH MONTH DAY YEAR <u>10 6 87</u>			2b HOUR <u>7 32 P.M.</u>				
3 SEX <u>Female</u>		4 RACE <u>Caucasian</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>4 23 11</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <u>0 0 0 0</u>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>PENNA. USA</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Washington County</u> MD				
10 CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hosp. Inc.</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>UK Homemaker</u>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <u>Maryland</u>			13b COUNTY <u>Washington</u>		13c CITY OR TOWN <u>Hancock</u>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <u>Albert UK Bowman</u>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary UK E. BARKMAN</u>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <u>UK</u>			16b SOCIAL SECURITY NO. <u>215-09-0472</u>	
17 INFORMANT			18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART FOUR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>10/5</u> 19 <u>87</u> to <u>10/6</u> 19 <u>87</u> that (I) (we) lost saw the deceased alive on <u>10/6</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>Thomas B. Haywood MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>10/6/87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas B. Haywood MD</u>				22e ADDRESS <u>354 M:11 St. Hagerstown, Md. 21740</u>			

MEDICAL CERTIFICATION

23a BURIAL, CREMATION, REMOVAL (EXCEPT) <u>Burial</u>		23b DATE <u>10/09/87</u>		23c NAME OF CEMETERY OR CREMATORY <u>Buck Valley Christian</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Wardensburg, Fulton, PENNA.</u>	
24 FUNERAL DIRECTOR NAME ADDRESS <u>Richard J. Gierke Hancock MD</u>				25a DATE REC'D. BY REGISTRAR <u>OCT 15 1987</u>			
25b REGISTRAR'S SIGNATURE <u>Julia Davidson-Rossell</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove stationers papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

069064 OCT 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) SHAYNA NICOLE SHEDD (KELLY)			2a DATE OF DEATH MONTH DAY YEAR 10 3 87			2b HOUR 5 ¹⁰ A M				
3 SEX FEMALE		4 RACE CAUS		5 DATE OF BIRTH MONTH DAY YEAR 10 3 87		6 AGE (IN YEARS (LAST BIRTHDAY)) N.B. YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD				
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Md.			13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE UNKNOWN 99999	
14 FATHER'S NAME FIRST MIDDLE LAST David Timothy Shedd			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Michelle Lee Kelley							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Amniotic Lungs</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Non Viable Fetus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22a SIGNATURE James M. Pribula, MD					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/3/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JAMES M. PRIBULA MD					22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b DATE 10-09-1987		23c NAME OF CEMETERY OR CREMATORY Washington County Hospital Hagerstown		23d LOCATION CITY OR TOWN COUNTY STATE Washington Md		23e DATE REC'D BY REGISTRAR	
24 FUNERAL DIRECTOR NAME Arun Kumar HD					ADDRESS W. CH		25a DATE REC'D BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE	

30 05 730 820 000

068238 OCT-9 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30070

1 DECEASED NAME (TYPE OR PRINT) Lillian Catherine Shirey			2a DATE OF DEATH MONTH DAY YEAR 10 5 87			2b HOUR 12:25 PM			
3 SEX Female		4 RACE Cauc		5 DATE OF BIRTH MONTH DAY YEAR 4 13 1997		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7a UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington Co.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colton Villa Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 12 South Walnut Street	
14 FATHER'S NAME FIRST MIDDLE LAST William E. Leiter				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Keller					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 164-28-6906		17 INFORMANT Helen Berger		ADDRESS 109 Manor Dr.		Apt. 103 Hag., Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Sickle Cell Anemia									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Abdul Wateed, MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/5/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL WATEED, MD			22e ADDRESS 1610 - Oak Hill Ave. Hagerstown, MD						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE October 7, 1987		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Maryland		
24 FUNERAL DIRECTOR NAME Minnich Funeral Home			24b ADDRESS 415 East Wilson Blvd. Hag. Md.			25a DATE REC'D BY REGISTRAR OCT 8 1987		25b REGISTRAR'S SIGNATURE Julia Tidmore-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

180-101 033830

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1. FOR
STATE
REGISTRAR

070607 NOV - 3 1987

2. DECEASED NAME (TYPE OR PRINT) Catherine B Shirley			3. DATE OF DEATH MONTH DAY YEAR 10 29 87			2b HOUR 6:30 AM	
3 SEX F	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 7 26 15		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Big Pool Md.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WCH			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Caretaker		12b KIND OF BUSINESS OR INDUSTRY Schools	
13a STATE MD.		13b COUNTY Washington	13c CITY OR TOWN Clear Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 15 S. Martin St. Clear Spring	
14 FATHER'S NAME FIRST MIDDLE LAST Russell Weller		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kelley					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) no		17 INFORMANT ADDRESS 15 S. Martin St. Ralph P. Shirley Clear Spring, MD.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF <u>MITRAL VALVULAR DIS.</u>			
DUE TO, OR AS A CONSEQUENCE OF <u>RHEUMATIC HEART DIS.</u>			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 73 to 10 28 19 87, that (I) (we) lost saw the deceased alive on 10 28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE 	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10.19.87
22d PHYSICIAN'S NAME (TYPE OR PRINT) OTIS ROZA		22e ADDRESS 100 LONG DRAGON DRIVE HAG. MD	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-31- 87	23c NAME OF CEMETERY OR CREMATORY Little Rose Hill	23d LOCATION (CITY OR TOWN) COUNTY STATE Clear Spring Wash. MD.
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24 FUNERAL DIRECTOR NAME Thompson Funeral Home Inc. Clear Spring Md	25a DATE REC'D BY REGISTRAR NOV 2 1987	25b REGISTRAR'S SIGNATURE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000

69088 OCT 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

30675

1 DECEASED NAME (TYPE OR PRINT) FLORENCE M. SMITH				2a DATE OF DEATH MONTH DAY YEAR 10-12-87		2b HOUR 10:49	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 11 1 1907		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.	
10 CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER		12b KIND OF BUSINESS OR INDUSTRY AUTO	
13a STATE MARYLAND		13b COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST HERMAN CARL PFLUG		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY AGNES DAMBAUGH		13e STREET ADDRESS / ZIP CODE 2209 DIANE DRIVE 21740			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b SOCIAL SECURITY NO 214-34-0171		17 INFORMANT ADDRESS H. CARL SMITH 208 JACKSON DRIVE HAG. MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Atherosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 OR PART 3)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (i) (the hospital) attended the deceased from <u>10/10/87</u> to <u>10/12/87</u> that (ii) (we) last saw the deceased alive on <u>10/12/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (i) was (we) did not view the body after death.							
22b SIGNATURE <u>George Newman II Ph.D.M.D.</u>		DEGREE		22c DATE SIGNED			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 10-14-87		23c NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE HAGERSTOWN WASH. MD.	
24 FUNERAL DIRECTOR NAME GERALD N. MINNICH		305 N. POTOMAC STREET HAGERSTOWN, MARYLAND		25a DATE REC'D BY REGISTRAR OCT 19 1987		25b REGISTRAR'S SIGNATURE <u>Julia Benson-Rudolph</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

2a DECEASED NAME (TYPE OR PRINT)			2b DATE OF DEATH			2c HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR			
Gay Pauline Smith			10	20	87	11:04P		M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 1 YEAR
Female	White	August 19, 1888		99				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
Eakles Mill, Md.			U. S. A.			9 BALTIMORE CITY OR COUNTY OF DEATH		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK OR NATURE OF WORKING LIFE)		
Boonsboro			Reeders Memorial Home			Homemaker		
12b KIND OF BUSINESS OR INDUSTRY			13a STATE			13b COUNTY		
Own Home			Maryland			Washington		
13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE		
Keedysville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			59 N. Main St. 21756		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?		
John E. Fisher			Catherine E. Kefauver			16b SOCIAL SECURITY NO		
						217-58-2709		
17 INFORMANT			ADDRESS			18 CAUSE OF DEATH		
Mr. Hugh Bernie Smith, Keedysville, Md.			21756			18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		

18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			18b SOCIAL SECURITY NO			17 INFORMANT		
PART I. DEATH WAS CAUSED BY			217-58-2709			ADDRESS		
IMMEDIATE CAUSE (a)			Heart Failure			Mr. Hugh Bernie Smith, Keedysville, Md. 21756		
DUE TO, OR AS A CONSEQUENCE OF			Coronary Artery Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						24 hrs		
DUE TO, OR AS A CONSEQUENCE OF						yrs		
DUE TO, OR AS A CONSEQUENCE OF								

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Parkinsons Disease; Generalized arthritis			24 hrs		

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
none	---	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)
	none 19	-
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> ON STREET <input type="checkbox"/> IN VEHICLE <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION (CITY OR TOWN, COUNTY, STATE)
	None	-

22a I certify that (1) (this hospital) attended the deceased from 12 19 86 to 10/20/87 19 that (1) (we) lost	
saw the deceased alive on 10/20/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.	
22b SIGNATURE	22c DATE SIGNED
William W. Lesh M.D.	10-21-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS		
William W. Lesh M.D.	411 Division Ave Hagerstown, Md.		
23a BURIAL, CREMATION, REMOVAL	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (CITY OR TOWN, COUNTY, STATE)
Burial	10-23-87	Fairview Cemetery	Keedysville, Wash. Co., Md.

24 FUNERAL DIRECTOR	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
John H. Bast, Jr. Boonsboro, Md. 21713	10/20/87	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

069858 OCT 27 1987

070015 OCT 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30677

1 DECEASED NAME (TYPE OR PRINT) NEVIN EDWARD SMITH			2a DATE OF DEATH October 20, 1987		2b HOUR M
3 SEX Male	4 RACE White	5. DATE OF BIRTH May 25, 1967		6 AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD	
10 CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland Frederick		13c CITY OR TOWN Frederick	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 31 West Patrick Street 21701	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Edward Smith		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Bernetta			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 177-30-9529		17 INFORMANT ADDRESS Elizabeth M. Smith Frederick, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from <u>2/12/83</u> 19 <u>83</u> to <u>10/20/87</u> 19 <u>87</u> that we (we) last saw the deceased alive on <u>10/20/87</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did not) view the body after death.					
22b SIGNATURE <u>A. Austin Pearre</u>				22c DATE SIGNED 10/20/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) A. Austin Pearre MD				22e ADDRESS Frederick, Maryland	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-23-87	23c NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.
24 FUNERAL DIRECTOR NAME Andrew K. Coffman Funeral Home, Inc.			25a DATE REC'D. BY REGISTRAR OCT 27 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT) George G. SNYDER			2a DATE OF DEATH MONTH DAY YEAR October 22 1987		2b HOUR 10:48 M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 25, 1909		6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 79	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b KIND OF BUSINESS OR INDUSTRY Legal

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Washington	13c CITY OR TOWN Clear Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 34 Cumberland St. 21722
14 FATHER'S NAME FIRST MIDDLE LAST Leonard P. Snyder			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie - Kratz			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b SOCIAL SECURITY NO 218-30-7525		17 INFORMANT ADDRESS Mrs. George G. Snyder (item 13 above)		

18 CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years
DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Bronchopneumonia		10 days
DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure		8 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Coronary Vessel Disease with Angina			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10/15 87 10/22 19 87	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (this hospital) attended the deceased from 10/22 87 to 10/22 19 87 that (I) (we) last saw the deceased alive on 10/22 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.	
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22b SIGNATURE Robert Bnull	DEGREE MD	22c DATE SIGNED 10/23/87
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert Bnull		22e ADDRESS 1459 Potomac Ave. Hagerstown

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Oct. 26, 1987	23c NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park	23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington MARYLAND
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24 FUNERAL DIRECTOR NAME ADDRESS Major M. Osborne Williamsport, MD 21795	25 DATE RECEIVED BY REGISTRAR OCT 30 1987	25b REGISTRAR'S SIGNATURE Julia Swenson-Randall
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1 - STATE REGISTRAR CLAUDE HARTLE SPESSARD
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (PRINT) Claude HARTLE Spessard			2a. DATE OF DEATH MONTH DAY YEAR 10-20-87			2b. HOUR 2²² PM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-7-03		6. AGE (IN YEARS, LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Officer		12b. KIND OF BUSINESS OR INDUSTRY Prison	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1111 Salem Avenue 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Clagget A. Spessard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Whitmore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 717-07-9363		17. INFORMANT Matin C. Spessard		18. ADDRESS 3125 La Kenta Circle Dallas Texas 75234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) probable pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (c) left sided hemiplegia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant instant 2 wks	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension diabetes m.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 61 to Oct 20 87 that (I) (we) lost saw the deceased alive on 10-20-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold R. Tritch Jr.				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. TRITCH				22e. ADDRESS 348 Mill ST HAGERSTOWN, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-24-87		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.			
24. FUNERAL DIRECTOR NAME Andrew K. Coffman Funeral Home, Inc.				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

070016 OCT 20 1951

CLAUDE HARTLEY 2-passed

10-20-87

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 DECEASED NAME (TYPE OR PRINT)			2a DATE KNOWN OF DEATH			2b DATE OF DEATH			2c DATE OF DEATH			2d HOUR							
Paul Arthur Stacer			10/11/1987			10/11/1987			10/11/1987			1:50 a.m.							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR	IF UNDER 24 HRS	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED							
male	white	Aug. 15, 1970	17 YRS			Maryland			USA			<input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a USUAL OCCUPATION			12b KIND OF BUSINESS OR INDUSTRY			9 BALTIMORE CITY OR COUNTY OF DEATH							
Hagerstown			Robinwood Drive			student						Washington County, MD							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS							
Maryland			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1842 Gilbert Ave. 21740							
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME					16a WAS DECEASED EVER IN U.S. ARMED FORCES?					16b SOCIAL SECURITY NO.				
Raymond J. Stacer					Betty Davis Lehman					no					219-06-1279				
17 INFORMANT										ADDRESS					Raymond Stacer, Hagerstown, Md.				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY

Smoke Inhalation

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

8902
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES ☒ NO ☐

21a EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY

12:15AM 10/11/1987

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

subject in house fire

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK

21e PLACE OF INJURY

basement

21f LOCATION

Robinwood Drive,

CITY OR TOWN

Washington

STATE

Md.

22a I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

Deputy Chief

MEDICAL EXAMINER

DATE SIGNED 10/12/87

EXAMINER'S NAME (TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS

111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (CITY OR TOWN)	23e COUNTY	23f STATE
burial	Oct. 13, 1987	Cedar Lawn Mem. Park	Hagerstown, Wash.,	Maryland	
24 FUNERAL DIRECTOR NAME			25a DATE REC'D BY REGISTRAR		
MINNICH FUNERAL HOME			OCT 16 1987		
415 E. Wilson Blvd., Hagerstown, Md. 21740			25b REGISTRAR'S SIGNATURE		
			Julia D. Dixon-Rudolph		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENAL SPACE 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

069316 OCT 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7-84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CECIL N STALEY			2a DATE OF DEATH MONTH DAY YEAR 10 7 87		2b HOUR 11:58 P M
3 SEX M	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 8-06-1936	6 AGE (IN YEARS LAST BIRTHDAY) 51	7 UNDER 1 YEAR MONTHS DATE HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. CO. MD	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH WASH. CO. MD		
10 CITY OR TOWN OF DEATH Hagerstown,	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist	12b KIND OF BUSINESS OR INDUSTRY Truck	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD. 13b COUNTY Washington 13c CITY OR TOWN Clear Spring			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 166 Main St. Clear Spring, MD 21722	
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Stley Newlin		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Lorean 217-32-7078	17 INFORMANT ADDRESS Carlene E. Staley Clear Spring, MD 166 Main St.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE UPPER G.I. HEMORRHAGE ASPIRATION WITH 30 MIN DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) UNRESECTABLE SQUAMOUS CELL CARCINOMA LEFT LUNG					
19a DATE OF OPERATION 10/3/87	19b CONDITION FOR WHICH OPERATION WAS PERFORMED FUNCTIONAL OBSTRUCTION OF ESOPHAGUS	20a AUTOPSY? CHEST ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from SEPT. 19 86 to 10/7 19 87 that (I) last saw the deceased alive on 10/2 19 87, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b SIGNATURE John R. Marsh, M.D.		DEGREE M.D.	22c DATE SIGNED 10/13/87		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. MARSH, M.D.		22e ADDRESS 239 N. POTOMAC ST HAGERSTOWN, MD. 21746			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 10-10-1987	23c NAME OF CEMETERY OR CREMATORY Little Rose Hill	23d LOCATION CITY OR TOWN COUNTY STATE Clear Spring, Wash. MD		
24 FUNERAL DIRECTOR NAME Thompson Funeral Home, Inc. Clear Spring, MD		25a DATE REC'D. BY REGISTRAR OCT 20 1987			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) LEE		FIRST A.		MIDDLE STOTTLEMYER		LAST STOTTLEMYER		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10/27/87 8:30 PM MATED <input type="checkbox"/>		2b DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 10/27/87 8:30 PM MATED <input type="checkbox"/>	
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH 12 DAY 30 YEAR 1904		6 AGE (IN YEARS) (LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YR. MONTH 0 DAY 0 HOURS 0 MIN 0		IF UNDER 24 HRS. HOURS 0 MIN 0		2c DATE PRONOUNCED DEAD 10/27/87 8:30 PM		2d HOUR
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON CO. MD					
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b KIND OF BUSINESS OR INDUSTRY GOVERNMENT			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE MD		13b COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 109 Clearview Road			
14 FATHER'S NAME FIRST AQUILLA MIDDLE STOTTLEMYER LAST STOTTLEMYER				15 MOTHER'S MAIDEN NAME FIRST ALMA MIDDLE D. LAST LIZAR							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO				16b SOCIAL SECURITY NO. 212-14-7066		17 INFORMANT Charles Stottlemeyer		ADDRESS Way, Germantown, MD 12305-J Silver Gate			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE - 428 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSELECTIC CARDIOVASCULAR DISEASE - 429 DUE TO, OR AS A CONSEQUENCE OF (c) DESENSE - 429 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I FRACTURED CERVICAL SPIRE - CHRONIC ALCOHOLISM -											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART II OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE George Milic				TITLE (SPECIFY) DEPUTY				MEDICAL EXAMINER 40 MANOR DR #103 HAGERSTOWN - MD - 21740			
EXAMINER'S NAME (TYPE OR PRINT) GEORGE MILIC, M.D.				ADDRESS HAGERSTOWN - MD - 21740				DATE SIGNED 10/27/87			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE 10/30/87		23c NAME OF CEMETERY OR CREMATORY of God Cemetery German town-Bethel Church		23d LOCATION CITY OR TOWN COUNTY STATE Cascade Washington MD			
24 FUNERAL DIRECTOR NAME G. DOUGLAS STAUFFER ADDRESS 1621 Opossumtown Pike, Frederick, MD 21701				25a DATE REC'D BY REGISTRAR NOV 2 1987		25b REGISTRAR'S SIGNATURE					

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

000-101-301

STATE OF NEW YORK

X 10/18/1910

10/18/1910

WASHINGTON DC

RECEIVED

10/18/1910

RECEIVED

10/18/1910

10/18/1910

10/18/1910

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10/18/1910

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X

10/18/1910

10/18/1910

10/18/1910

10/18/1910

10/18/1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH: 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1 - FOR
STATE
REGISTRAR

DECEASED NAME (PRINT OR PRINT) Charlotte Lorraine Swope		2a. DATE OF DEATH MONTH DAY YEAR October 23, 1987		2b. HOUR M 10	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 10 1941	6 AGE (IN YEARS LAST BIRTHDAY) 46	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 0 0 0	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington		
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY MD	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Mt. Lena	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Route 2 21713
14 FATHER'S NAME FIRST MIDDLE LAST Floyd Daniel Swope		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Paisy Arbutus Arnold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-46-1163	17 INFORMANT ADDRESS John Bussard Rt. 2 Box 307 Boonsboro, Maryland 21713			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins 1 hour years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Extreme Obesity, Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-19 19 76 to 10-21 19 87 that (I) (we) last saw the deceased alive on 10-21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles R Wierer MD				DEGREE MD	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles R. Wierer MD.				22e. ADDRESS Boonsboro Md.	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE October 26 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Lena Cemetery	
23d. LOCATION (CITY OR TOWN) Mt. Lena		23e. COUNTY Washington		23f. STATE Md.	
24 FUNERAL DIRECTOR NAME John H. Bast Jr.		ADDRESS Rfd. 4 Box 7 21713		25a. DATE REC'D BY REGISTRAR OCT 28 1987	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			

93 80 190 0 54 0 5

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ALAN Foster TAYLOR			2a DATE OF DEATH October 28, 1987		2b HOUR M
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR June 23, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS	IF UNDER 1 YEAR IF UNDER 1 YEAR IF UNDER 1 YEAR
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) truck driver		12b KIND OF BUSINESS OR INDUSTRY county govern.
13a STATE Maryland		13b COUNTY Washington	13c CITY OR TOWN Hagerstown	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 11 W. Baltimore St. 21740
14 FATHER'S NAME FIRST MIDDLE LAST Harry Foster Taylor		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl B. Robinette			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-24-8339	17 INFORMANT ADDRESS Betty Taylor, Hagerstown, Md.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) advanced metastatic carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 10/4/87 to 10/28/87, that (I) (we) last saw the deceased alive on 10/28/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.					
22b SIGNATURE Dr. Bandy		DEGREE		22c DATE SIGNED 10/30/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) B. C. BANDY		22e ADDRESS 363 S. Cleveland Ave			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Oct. 30, 1987	23c NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland
24 FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a DATE REC'D. BY REGISTRAR NOV 04 1987		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 NORTH MAP

070025 101-251



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

10

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF VITAL RECORDS, 201 W. PEBBLE BEACH STREET, ATWATER, CALIFORNIA 95301.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST VINCENT H. TIMMONS										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10/27 1987 4:21 PM	
3. SEX Male										2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 10/27 1987 4:21 PM	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 14, 1919 68 YRS		6. AGE (IN YEARS) LAST BIRTHDAY MONTH DAY 10/27 1987 4:21 PM		7. IF UNDER 1 YR MONTHS DATE HOURS MIN		8. IF UNDER 24 HRS HOURS MIN			
9a. BIRTHPLACE STATE OR FOREIGN COUNTRY Pa.		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON CO. MD		12. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON CO. MD			
13. CITY OR TOWN OF DEATH Hagerstown		14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Washington Co. Hosp.		15. USUAL OCCUPATION (TYPE OF WORK) Truck Driver		16. KIND OF BUSINESS OR INDUSTRY Trucking		17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Pa. Franklin Mercersburg			
18. FATHER'S NAME FIRST MIDDLE LAST Jacob Webster Timmons		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Eliza Smith		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WW II		21. SOCIAL SECURITY NO. 220-05-6247		22. INFORMANT Mary Jane Timmons			
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) AORTIC ABDOMINAL ANEURYSM, RUPTURED 3 HOURS DUE TO, OR AS A CONSEQUENCE OF (b) #441 DUE TO, OR AS A CONSEQUENCE OF (c)										24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17236	
25. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) TRAUMATIC INJURIES FROM FALL										26. DATE OF OPERATION 19a	
27. CONDITION FOR WHICH OPERATION WAS PERFORMED? 19b										28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
29. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21a										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										21d. LOCATION CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
23a. ACTUAL SIGNATURE George Milic, MD										23b. TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER	
23c. EXAMINER'S NAME (TYPE OR PRINT) GEORGE MILIC, MD										23d. DATE SIGNED 10/27/87	
23e. ADDRESS 40 MANOR DR #103 HAGERSTOWN, MD 21740										23f. ADDRESS HAGERSTOWN, MD 21740	
24a. BURIAL, CREMATION, REMOVAL Burial										24b. DATE 10/31/87	
24c. NAME OF CEMETERY OR CREMATORY Welsh Run Brethren										24d. LOCATION CITY OR TOWN COUNTY STATE Montgomery Twp. Franklin, Pa.	
24e. DATE REC'D BY REGISTRAR 6 NOV 02 1987										24f. REGISTRAR'S SIGNATURE [Signature]	

ADDRESS Mercersburg, Pa. 1723

25a. DATE REC'D BY REGISTRAR
6 NOV 02 1987

75b REGISTRAR'S SIGNATURE

071207 104105

VINCENT H. TIMMONS

10/27/42

10/27/42

WASHINGTON 60

WASHINGTON CO. 60

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

30080

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
JEAN Elizabeth TROTTA

2a DATE KNOWN OF DEATH ESTI MATED ☒ MONTH DAY YEAR 10-29-87 7d HOUR M 4:45a

3 SEX Female 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR May 25, 1924 6 AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS. 7c DATE PRONOUNCED DEAD 10-29-87 7d HOUR 4:45a

8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna 7b CITIZEN OF WHAT COUNTRY? United States 8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD

10 CITY OR TOWN OF DEATH Hagerstown 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Washington County Hospital 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker 12b KIND OF BUSINESS OR INDUSTRY

13a STATE Penna. 13b COUNTY Fulton 13c CITY OR TOWN Warfordsburg 13d INSIDE CITY LIMITS? YES ☐ NO ☒ 13e STREET ADDRESS Rt. 1 Box 1215 117267

14 FATHER'S NAME FIRST MIDDLE LAST Claude Hershey Metzger 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen H. Harris

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b SOCIAL SECURITY NO. 578 26 6941 17 INFORMANT ADDRESS Louis J. Trotta, Sr. same as 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ~~XXXXXXXXXXXX~~ disease (b) DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a diabetes mellitus

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 20 AUTOPSY? YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) 21f LOCATION CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE *Dennis F. Smyth* MEDICAL EXAMINER DATE SIGNED 10-29-87 EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 11/2/87 23c NAME OF CEMETERY OR CREMATORY Cedar Grove 23d LOCATION CITY OR TOWN COUNTY STATE Warfordsburg, Fulton, Penna.

24 FUNERAL DIRECTOR NAME *Richard J. Chene Hancock* ADDRESS *MD.* 25a DATE REC'D BY REGISTRAR NOV 5 1987 25b REGISTRAR'S SIGNATURE *John W. Hancock*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 10, "RETURN PAGE 5 FOR YOUR FILES." TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 84 BP DHMH - 17 (VR A15 ME (5))

100-101-50015

RECEIVED

MINUTES



071068

NOV-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30687

FOR
1- STATE
REGISTRAR

DECEASED NAME

(TYPE OR PRINT)

FIRST

MIDDLE

LAST

GRACE

Mable VAUGHN

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

10-27-87

M

3 SEX

Female

4 RACE

White

5 DATE OF BIRTH

December 10, 1910

6 AGE (IN YEARS (LAST BIRTHDAY))

76

IF UNDER 1 YEAR

IF UNDER 1 YEAR

7a BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

PA

7b CITIZEN OF WHAT COUNTRY?

U. S. A.

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Washington County

MD

10 CITY OR TOWN OF DEATH

Hagerstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Western Maryland Center

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer

12b KIND OF BUSINESS OR INDUSTRY

Rubber

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

Maryland

13b COUNTY

Frederick

13c CITY OR TOWN

Emmitsburg

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

9402 Waynesboro Pike 21727

14 FATHER'S NAME

Oliver

MIDDLE

LAST

Sheeley

15 MOTHER'S MAIDEN NAME

Emma

MIDDLE

LAST

Wetzel

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO

216-22-9157

17 INFORMANT

Virginia G. Vaughn 9402 Waynesboro Pike

ADDRESS

Emmitsburg MD 21727

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

D Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b) CHF

DUE TO, OR AS A CONSEQUENCE OF

B GI Bleeding

(c)

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

days

Months

Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐NO ☐

21a ACCIDENT WAS UNDERLYING

☐

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (this hospital) attended the deceased from 3-12-1987 to 10-27/87 that I (we) last

saw the deceased alive on 10-27-87 19 and that in my (our) opinion death occurred on the date and hour and from the cause stated

above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

Milaninia M.D.

DEGREE

M.D.

ATTENDING

PHYSICIAN ☐

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☒

22c DATE SIGNED

10/27/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

MILANINIA

22e ADDRESS

1500 Pennsylvania Ave HAGERSTOWN MD

23a BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b DATE

30 Oct 87

23c NAME OF CEMETERY OR CREMATORY

Emmitsburg Memorial

23d LOCATION

CITY OR TOWN

COUNTY

STATE

Emmitsburg, Frederick, MD

24 FUNERAL DIRECTOR

Skiles Funeral Home, Emmitsburg, MD 21727

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

NOV 04 1987

DIVISION OF VITAL RECORDS, 2D1 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be given to the funeral director. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

3

FEB 1968

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMH - 16 60M 7 B4
(VRS 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) Donna I. Virts		2a DATE OF DEATH MONTH DAY YEAR 10-10-87		2b HOUR 3:30 AM	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR August 3, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b KIND OF BUSINESS OR INDUSTRY retail sales	
13a STATE Maryland		13b COUNTY Washington		13c CITY OR TOWN Hagerstown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 1048 S. Potomac St. 21740		14 FATHER'S NAME FIRST MIDDLE LAST John W. Birkett		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Hunt			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-30-9194A		17 INFORMANT ADDRESS G. William Virts, Hagerstown, Md.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 4 weeks DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-0 Respiratory failure secondary to							
19a DATE OF OPERATION 9/26/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED 2nd cancer of per. colon after 1st		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 3			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10/9/87 to 10/10/87 that (I) (we) lost the deceased on 10/10/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b SIGNATURE C. S. [Signature]				DEGREE MD		22c DATE SIGNED 10/10/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) C. S. [Signature]				22e ADDRESS 370 Mill St. Hagerstown Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Oct. 13, 1987		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a DATE REC'D BY REGISTRAR OCT 16 1987		25b REGISTRAR'S SIGNATURE Julia [Signature]	

069789-10/29/87

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87-30689

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Eleanor Mae WALKER		2a DATE OF DEATH MONTH DAY YEAR October 17, 1987		2b HOUR 1:40pm	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR January 14, 1917	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montana		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland		13b COUNTY Prince Geo.		13c CITY OR TOWN Oxon Hill	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1313 Southern Ave. 20745			
14 FATHER'S NAME FIRST MIDDLE LAST William J. Roney		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Ness			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 217-22-7395		17 INFORMANT 742 Bluff St., Apt. 204 Mrs. Frances Quillinan, Carol Stream, Ill.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Active Hepatitis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 12/10 19 86 to 10/17 19 87 that (I) (we) lost saw the deceased alive on 10/17 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b SIGNATURE Rose Marie Chan, M.D.		DEGREE M.D.		22c DATE SIGNED 10/17/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROSE MARIE CHAN, M.D.		22e ADDRESS Western Maryland Ctr, Hagerstown, Md. 21740			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Oct. 19, 1987		23c NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d LOCATION (CITY OR TOWN) Hagerstown, Wash., Maryland		23e DATE REC'D BY REGISTRAR DEC 10 1987			
24 FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME		24b ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Hebert, George
Grove, John

1015 N. Main St., N.Y.
N.Y. 10001
N.Y. 10001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) NELLIE FLORENCE WAUGH			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 26 1987			2b HOUR 6:55 P.M.			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR SEPT. 24 1892		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7a UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.			
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLTON VILLA NURSING HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) KITCHEN HELP		12b KIND OF BUSINESS OR INDUSTRY RESTRURANT	
13a STATE MARYLAND		13b COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 115 N. JONATHAN STREET 21740	
14 FATHER'S NAME FIRST MIDDLE LAST THOMAS WARREN WAUGH			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY SUSAN WAUGH			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b SOCIAL SECURITY NO. 234-14-0666			17 INFORMANT MEDA CROUSE				ADDRESS SAME AS 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 - 10 YEARS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (1) XXXXXX attended the deceased from MARCH 20 19 85 to OCTOBER 26 19 87 that (1) XXXXXX lost saw the deceased alive on OCTOBER 22 19 87 and that in my XXXXXX opinion death occurred on the date and hour and from the causes stated above, (1) XXXXXX did not view the body after death.									
22b SIGNATURE <i>Edward W. Ditto, III</i> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED Oct. 27, 1987	
22d PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. DITTO, III, M.D.						22e ADDRESS 217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 10-29-87		23c NAME OF CEMETERY OR CREMATORY GREEWAY CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE BERKELEY SPRINGS W. VA.		
24 FUNERAL DIRECTOR NAME GERALD N. MINNICH						25a DATE REC'D. BY REGISTRAR OCT 30 1987		25b REGISTRAR'S SIGNATURE <i>Richard R. ...</i>	

070718 NOV-58

2010

NOV 19 1958

RECEIVED IN LANSING AIR MAIL

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [illegible]

NY 100-100000

RE: [illegible]

RE: [illegible]

070166 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30091

1 DECEASED NAME (TYPE OR PRINT) Hazel May Webber			2a DATE OF DEATH MONTH DAY YEAR October 24, 1987		2b HOUR 6:50 P.M.
3 SEX female	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR August 30, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS. MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Washington 13c CITY OR TOWN Hagerstown			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 201 Nottingham Road 21740	
14 FATHER'S NAME FIRST MIDDLE LAST Harry Yeager		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 74 2348		17 INFORMANT ADDRESS George W. Webber, Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>COLON CANCER</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>10-21</u> , 19 <u>87</u> to <u>10-24</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Eld Roza		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT) ELD ROZA		22e ADDRESS WASHINGTON COUNTY HOSPITAL			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b DATE Oct. 27, 1987	23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland
24 FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a DATE REC'D. BY REGISTRAR OCT 28 1987 25b REGISTRAR'S SIGNATURE		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30692

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Lester B WHETZEL		2a. DATE OF DEATH MONTH DAY YEAR 10-26-87		2b. HOUR 3:40 A.M.	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR October 12 1899		6 AGE (IN YEARS LAST BIRTHDAY) 87	7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Williamsport Nursing Home		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Williamsport	
14 FATHER'S NAME FIRST MIDDLE LAST James L. Whetzel		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah C. Dove		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-10-3930		17. INFORMANT ADDRESS Charles Whetzel, Mayo, Maryland 21106	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration of gastric contents DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Intestinal Obstruction DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) May		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19801 Marden Lane Olney, Maryland 20832	
22a. I certify that (1) this hospital attended the deceased from Oct 13-15 , 19 86 to Oct 26 , 19 87 that (2) we last saw the deceased alive on Oct 1 , 19 87 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (3) we (did/did not) view the body after death					
22b. SIGNATURE Ted E Howe MD				22c. DATE SIGNED 10-26-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ted E Howe				22e. ADDRESS 19801 Marden Lane Olney, Maryland 20832	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Balt/Wash. Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.		23e. NAME OF CEMETERY OR CREMATORY Balt/Wash. Crematory			
24 FUNERAL DIRECTOR NAME Barber Funeral Home, Laytonsville, Md. 20879		ADDRESS 20879		25a. DATE REC'D. BY REGISTRAR OCT 28 1987	
25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070117 OCT 29 87

1985

070117

069777 OCT 25-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

30693

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hubert Oscar WILLIAMS			2a DATE OF DEATH MONTH DAY YEAR October 12, 1987		2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTH DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN) Country Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 10		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitor		12b KIND OF BUSINESS OR INDUSTRY Truck Co.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY Wash. 13c CITY OR TOWN Hagerstown			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST William S. Williams			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Whitmore		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b SOCIAL SECURITY NO. 215-26-2076		17 INFORMANT ADDRESS Naomi Mary Williams Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Violent Administration of Barbiturate</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-16-82
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (a) (this hospital) attended the deceased from 12-11-87 19 58 to 10-12-87 19 82 that (b) (we) last saw the deceased alive on 10-8-87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we) did (and not) view the body after death.					
22a SIGNATURE <i>Charles F. Hess M.D.</i> DEGREE				22c DATE SIGNED 10-16-87	
22b PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess M.D.				22e ADDRESS Smithsburg MD	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct. 15, 1987		23c NAME OF CEMETERY OR CREMATORY Stouffer's Mennonite Cemetery	
23d LOCATION Greensburg, Wash, Md.		23e DATE REC'D BY REGISTRAR Oct 23 1987		23f REGISTRAR'S SIGNATURE <i>John Davidson-Rodden</i>	
24 FUNERAL DIRECTOR <i>David Funeral Home</i> Smithsburg, Md.					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR JOHN MC CANN WOLFE					REG. NO. 30694				
1. DECEASED NAME (TYPE OR PRINT) JOHN McCANN WOLFE					2a. DATE OF DEATH MONTH 10 DAY 20 YEAR 87			2b. HOUR 1:23A.M.	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 6 DAY 11 YEAR 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOUR MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, Maryland MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Expediter		12b. KIND OF BUSINESS OR INDUSTRY Aircraft Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Washington 13d. CITY OR TOWN Hagerstown					13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME (FIRST MIDDLE LAST) Frank K. Wolfe					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Rose Mary Mc Cann				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 216-14-6479		17. INFORMANT (NAME AND ADDRESS) Elizabeth R. Wolfe 204 O'Toole Drive Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary insufficiency (b) (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION (CITY OR TOWN STREET) Hagerstown, Md.		21g. COUNTY Washington		21h. STATE Md.	
22a. I certify that (1) this hospital attended the deceased from 10/17/87 to 10/21/87 , that (2) we last saw the deceased alive on 10/17/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, or we did not view the body after death.									
22b. SIGNATURE Charles R. Chaney M.D.				DEGREE M.D. 22c. DATE SIGNED 10/21/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles R. Chaney M.D.				22e. ADDRESS Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-22-87		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (CITY OR TOWN COUNTY STATE) Hagerstown, Washington, Maryland			
24. FUNERAL DIRECTOR (NAME AND ADDRESS) Andrew K. Coffman Funeral Home, Inc. Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR OCT 27 1987		25b. REGISTRAR'S SIGNATURE 			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30695

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Ruth YEAKLE			2a DATE OF DEATH MONTH DAY YEAR October 28, 1987		2b HOUR M
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR December 17, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary	12b KIND OF BUSINESS OR INDUSTRY automobile	
13a STATE Maryland			13b COUNTY Washington	13c CITY OR TOWN Williamsport	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Jacob D. Carl			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Carbaugh		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-9613	17 INFORMANT ADDRESS Berkley C. Yeakle, Williamsport, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>J. D. Wooster</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/28/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 1825 Howell Road Hagerstown MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b DATE Oct. 31, 1987	23c NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24 FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740		25a DATE REC'D. BY REGISTRAR NOV 04 1987		25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

30690

1. DECEASED NAME (TYPE OR PRINT) Francis Millspagh Yellott Sr.			2a. DATE OF DEATH MONTH DAY YEAR October 7, 1987		2b. HOUR 4 A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 27, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10. CITY OR TOWN OF DEATH Smithsburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 2		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber	12b. KIND OF BUSINESS OR INDUSTRY Mack Truck	
13a. STATE Md.			13b. COUNTY Wash.	13c. CITY OR TOWN Smithsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Yellott			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances A. Reisler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 220-18-3027		17. INFORMANT ADDRESS Mrs. Norma J. Yellott Smithsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>10/2</u> 19 <u>86</u> to <u>10/7</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>10/2</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Frederick H. Gross III</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED 10/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick H. Gross III		22e. ADDRESS 1825 Howell Road Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 10, 1987	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg, Wash, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Davis Funeral Home Smithsburg, Md.		25a. DATE REC'D. BY REGISTRAR OCT 13 1987			
		25b. REGISTRAR'S SIGNATURE <u>John Seiden</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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